SITUATIONAL ANALYSIS:

A Background Paper on HIV/AIDS & Aboriginal People

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A Background Paper on
HIV/AIDS and Aboriginal People

Prepared for the
Special Working Group on Aboriginal Issues,
Ministerial Council on HIV/AIDS

Table of Contents

Glossary of Abbreviations

AASO	Aboriginal AIDS Service Organization
ACAP	AIDS Community Action Program
AFN	Assembly of First Nations
AHRDS	Aboriginal Human Resources Development Strategy
APHA	Aboriginal Persons Living with HIV/AIDS
APS	Aboriginal Peoples Survey
ASO	AIDS Service Organization
BHST	Bureau of HIV/AIDS, STD & TB
BNA Act	British North America Act
CAAN	Canadian Aboriginal AIDS Network
CAP	Congress of Aboriginal Peoples
CAPC	Community Action Plan for Children
CAS	Canadian AIDS Society
CHDP	Community Health Demonstration Program
CHR	Community Health Representative
CIHR	Canadian Institutes of Health Research
CPNP	Canada Prenatal Nutrition Program
CSC	Correctional Services of Canada
CSHA	Canadian Strategy on HIV/AIDS
DAAC	Departmental Aboriginal AIDS Committee
DIAND	Department of Indian Affairs and Northern Development
FAS/FAE	Fetal Alcohol Syndrome/Fetal Alcohol Effect
FN	First Nations
FNHIS	First Nations Health Information System
FNIRHS	First Nations and Inuit Regional Health Survey
FPT AIDS	Federal/Provincial/Territorial Advisory Committee on AIDS
HPPB	Health Promotion and Programs Branch

HRDC	Human Resources Development Canada
IACB	Information, Analysis and Connectivity Branch
ICHAAP	Interbranch Committee on HIV/AIDS and Aboriginal People
IDU	Intravenous Drug User
ITC	Inuit Tapirisat of Canada
JNC	Joint National Committee
LCDC	Laboratory Centre for Disease Control
MNC	Métis National Council
FNIHB	First Nations & Inuit Health Branch
MSM	Men who have Sex with Men
NCA	National Childrens Agenda
NAFC	National Association of Friendship Centres
NARGHA	National Aboriginal Reference Group for HIV/AIDS
NAS	National AIDS Strategy
NEP	Needle Exchange Program
NHRDP	National Health Research and Development Program
NIB	National Indian Brotherhood
NIHB	Non-Insured Health Benefits
NNADAP	National Native Alcohol and Drug Program
NWAC	Native Womens Association of Canada
OAAPH	Organization for the Advancement of Aboriginal Peoples' Health
PPHB	Population and Public Health Branch
RCAP	Royal Commission on Aboriginal Peoples
RFP	Request For Proposals
STD	Sexually Transmitted Disease
SWGAI	Special Working Group on Aboriginal Issues
TB	Tuberculosis

Executive Summary

In 1999, the Ministerial Council on HIV/AIDS Special Working Group on Aboriginal Issues (SWGAI) decided that to develop informed policy recommendations to the Minister regarding HIV/AIDS and Aboriginal people, there was a need to establish a common level of understanding of policy and systems among Ministerial Council members and Aboriginal stakeholders. The SWGAI recommended that a foundation document be prepared that provided high level synthesis and systems analysis of existing reports and activities regarding Aboriginal health and HIV/AIDS.

The resulting document is Situational Analysis: HIV/AIDS and Aboriginal People. This document provides an overview of the current state of health, well being and social status of Aboriginal people in Canada, within a historical context. The content includes a description and history of each of the national Aboriginal organizations and government departments concerned with health and social policy, programming, and service delivery to Aboriginal people; the major forces shaping health and social policy for Aboriginal people including treaties and legislation; and a discussion of HIV/AIDS among Aboriginal people including epidemiology, past and current policy and program initiatives, and unresolved issues.

The *Situational Analysis* was written for Ministerial Council members, Aboriginal stakeholders and federal, provincial, and territorial policy makers to provide a solid policy foundation from which to develop and evaluate recommendations to the Minister regarding the prevention, care, treatment and support of Aboriginal peoples under the Canadian Strategy on HIV/AIDS (CSHA).

In the 1996 census, Aboriginal people, comprising First Nations, Métis and Inuit, were reported to number 799,100 or approximately 3% of the Canadian population. The largest proportion were First Nations, both status and non-status (called North American Indian in census data), followed by the Métis and Inuit. The Aboriginal population in 1996 was 10 years younger on average than the general Canadian population, with a higher birth rate. Although Aboriginal people have a lower life expectancy at birth when compared to other Canadians, this indicator is improving as a result of lowered mortality rates and the gap between these two populations is expected to continue to narrow.

Health Status

The health of Aboriginal people experienced a decline after contact with Europeans for numerous reasons including the transmission of new diseases, loss of traditional lifestyle, change to a less nutritious diet, depletion of food sources caused by over hunting and fishing, confinement to the reserve system and the development of the residential school system. Aboriginal people have continued to experience poorer health and to live in generally depressed socio-economic conditions. Compared to the general population, mortality and morbidity rates are higher, and chronic degenerative diseases such as diabetes, arthritis and cardiovascular disease are recognized as significant health concerns. Socio-economic indicators point to increased rates of unemployment, welfare dependency, conflict and incarceration, and lower family income and educational achievement in Aboriginal communities.

Federal Initiatives in Aboriginal Health

Aboriginal policy landmarks in the last two decades include the enshrinement of existing Aboriginal and treaty rights in the *Canadian Constitution, 1982*; the recognition by the federal government of the inherent right of self-government of Aboriginal peoples; the clarification in the Canadian courts on federal fiduciary responsibilities to Aboriginal people; the report of the Royal Commission on Aboriginal peoples; and the subsequent federal response to this report, *Gathering Strength*. Major health and health-related initiatives of the federal government which are directed to Aboriginal people include the Aboriginal Healing Foundation, Centre for the Advancement of Aboriginal Peoples' Health, Aboriginal diabetes initiative, Aboriginal Head Start and the Aboriginal Human Resources Strategy. First Nations and Inuit specific federal initiatives include First Nations and Inuit Home and Community Care, the First Nations Health Information System, and the First Nations Telehealth Project. A new wave of the Aboriginal Peoples Survey and the First Nations and Inuit Regional Longitudinal Health Survey is being planned for 2001.

HIV/AIDS and Aboriginal People

Over the past decade, the AIDS epidemic has risen steadily in the Aboriginal population in Canada. Of the 85% of total AIDS cases with known ethnic status, the proportion of Aboriginal cases rose from 1% before 1990 to 15% in 1999 (see Figure 4). From the beginning of the epidemic to December 31, 1999, out of 16,913 cumulative AIDS cases reported to the National AIDS Case Reporting and Surveillance System, 371 were indicated as Aboriginal. The majority of these cases are male (78%) and the most common exposure categories are men who have sex with men (52.4%), injection drug users (24.0%), men who have sex with men/injection drug users (13.2%). For Aboriginal women, injection drug use (58.5%) and heterosexual activity (24.4%), are the most commonly identified exposure categories.

In the last ten years of the HIV/AIDS epidemic, there has been a shift in exposure categories from men who have sex with men to injection drug use. In the adult female population, the shift has been from heterosexual sex to injection drug use. As of December, 1999, compared to non-Aboriginal AIDS cases, Aboriginal AIDS cases are younger and more likely to be attributed to injection drug use. In addition, the proportion of women among Aboriginal AIDS cases is almost triple that of non-Aboriginal AIDS cases.

Transmission of HIV is facilitated by high rates of sexually transmitted diseases, substance abuse, and other health and social issues. Unemployment, low incomes, receipt of social assistance, lack of stable housing, low educational attainment, and mobility have been identified as risk factors in recent studies of Aboriginal people with HIV/AIDS. Other HIV/AIDS risk factors associated with socio-economic status include low rates of condom use, increased risk of sexual abuse or non-consensual sex, poor self esteem and inability to demand safe sexual practices or decline sex, increased alcohol and drug use which predisposes to high risk behaviours and over representation of Aboriginal people in settings where there is an increased risk of HIV contact, such as in prison and on the street.

The Canadian Strategy on HIV/AIDS

The Aboriginal component of the CSHA is characterized by active participation of Aboriginal people and dedicated funding to this population in on-reserve, rural and urban locations. It is a broad strategic response across the strategy, involving the areas of prevention, community development, care, treatment and support, epidemiology and surveillance and improved coordination of HIV programming.

Critical Issues in HIV/AIDS and Aboriginal People

Structural and jurisdictional factors in the provision of health services to Aboriginal communities result in issues which span the HIV/AIDS prevention through treatment/support continuum. Geography, isolation and small community size influence accessibility to services and comprehensiveness of services in communities. The split of jurisdiction for certain health services between the federal government (First Nations on reserve and Inuit communities) and the provincial governments (non-reserve populations, including non-status, First Nations off-reserve and Métis) may cause gaps in services, poor continuity of care, difficulties in accessing services and funding restrictions to Aboriginal AIDS service organizations.

Access to services can also be impeded by cultural differences in the types of health programs offered or the way they are delivered. Aboriginal people have advocated for the provision of health services by Aboriginal professionals, in the community if possible, using educational materials and processes which are sensitive to language and culture. Traditional practices which have been reported as successful or beneficial include those founded on the Medicine Wheel and Healing Circle, Aboriginal holistic approaches to healing.

Communities themselves may present barriers to care, through restrictive values which do not welcome Aboriginal people with HIV/AIDS into communities, or a lack of professional capacity to deal with HIV/AIDS.

Issues that have been raised in the past concerning the CSHA funding processes include a lack of capacity in Aboriginal communities to prepare successful project proposals, and concerns that existing processes are inequitable and not culturally sensitive. These issues are being currently being addressed by advisory bodies and consultative processes of the funding programs, which have instituted changes such as peer review of proposals which utilize a majority Aboriginal committee, and criteria which look at project relevance.

Aboriginal people desire a greater participation in decision making processes when relevant government policy is developed or other issues of importance to Aboriginal people are discussed by governments. A climate of partnerships has been fostered by the federal *Gathering Strength* approach, and has resulted in Aboriginal participation in joint steering committees, working groups, advisory bodies and interjurisdictional collaborations. With respect to HIV/AIDS, approaches and strategies will require Aboriginal ownership and control for maximum effectiveness, aided by links to federal and provincial services, capacity building and community development, a holistic approach, and a focus on special groups such as youth, women and intravenous drug users.

PART I: Aboriginal People In Canada

Introduction

This situational analysis has been prepared for the Ministerial Council on HIV/AIDS to provide a socio-political perspective on health-related issues in the HIV/AIDS epidemic which has faced Aboriginal populations in Canada for the past ten years. First Nations, Métis and Inuit people receive health services in an environment ruled by legal definitions and defined by government jurisdictions. Definitions are important for a number of reasons. When honouring past treaties and agreements which the British Crown negotiated with Aboriginal peoples, definitions clarify the groups involved in these agreements. Definitions which delineate Aboriginal groups help preserve cultural integrity and avoid all descendants of the original inhabitants of Canada and North America from being lumped into one generic population. The presence of 52 indigenous linguistic groups in Canada gives proof of the many diverse cultures which existed prior to European contact.

Definitions are again important when governments determine responsibilities for provision of services to Aboriginal people. For many reasons, as will be elaborated, Aboriginal people have an increased need for health and social services compared to the general Canadian population, and the isolation of many Aboriginal communities compounds the cost of these services. *The British North America (BNA) Act, 1876* mandated the federal government with legislative authority for "Indians and lands reserved for the Indians." The provinces disclaim responsibility for many services to First Nations (Indian) communities based on this *BNA Act* clause. Not surprisingly, in practice the application of some Aboriginal definitions to eligibility for services is not clear cut and may create grey areas or gaps in services with the result that some Aboriginal groups have found difficulty accessing services from provincial and federal government sources. These issues will be explored in detail in this report. Perhaps because of the seriousness of HIV/AIDS as a disease, the high acuity of illness it brings, and the complexity of services required, HIV/AIDS serves to magnify the effect of issues of jurisdiction and access to services. Of course, service issues are not totally related to accepted definitions of different Aboriginal populations and their corresponding eligibility for services. Even so, a good starting point in unravelling and clarifying issues surrounding HIV/AIDS and Aboriginal people, will be an explanation of Aboriginal terminology which begins Part I of this report.

The section on definitions and population characteristics is followed by an overview of national Aboriginal organizations which have an advocacy and representative role in health policy. A look at the reasons for the decline of Aboriginal health is accompanied by a succinct description of the major health issues facing Métis, First Nations and Inuit peoples today.

Much of the First Nations, Inuit and Métis' contemporary approaches to health services are interwoven with the desire for self-government and self-determination. A section on rights and responsibilities addresses this topic and describes Aboriginal and treaty rights, and the fiduciary responsibility of the federal government towards Aboriginal people. Current initiatives of the federal government in health and health-related areas are then described.

Part II, Aboriginal People and HIV/AIDS, begins with a trend analysis of HIV/AIDS among the Aboriginal population which has been completed by the Bureau of HIV/AIDS, STD and TB, Health Canada. The Aboriginal specific components of the Canadian Strategy on HIV/AIDS (CSHA) are then described, as are the committees at the federal level which have an advisory role in this aspect of the CSHA.

The last section of Part II analyses critical issues surrounding approaches to HIV/AIDS and Aboriginal people, which includes structural and jurisdictional barriers, traditional healing approaches, and CSHA funding limitations, among others. This descriptive paper ends with a look at existing approaches to service delivery and recommendations from other fora on the issue of Aboriginal people and HIV/AIDS.

Definitions

Aboriginal terminology is not static. Indian people as defined by the *Indian Act, 1876* are now commonly called First Nations; the term Eskimo has given way to Inuit. "Aboriginal" itself is considered value-laden as it has been associated with primitive peoples, and some have chosen to use the word indigenous instead. However, the Royal Commission on Aboriginal Peoples (RCAP) has defined the term "Aboriginal People" to include "organic political and cultural entities that stem historically from the original peoples of North America, rather than collections of individuals united by so-called 'racial' characteristics."[1] This term includes the Indian, Métis and Inuit peoples of Canada defined in section 35(2) of *The Constitution Act, 1982*.

Indian

The *Indian Act, 1876* section 2(1) defines Indian as a person who pursuant to the Act "is registered as an Indian or is entitled to be registered as an Indian." This definition created the category of "status" or "registered" Indian. However, some Indians are not included within this legal definition. For example, this non-status group includes those persons who lost their status for a variety of reasons, such as military enlistment and marriage to non-Indian men, and those persons who were never registered in the first place.

Bill C-31 which was passed in 1985 sought to remedy this loss of status through these restrictive measures of the *Indian Act*. As a result, approximately 100,000 Indians and Métis have been reinstated or registered under Bill C-31. The Canadian census stated that in 1991, there were still at least 250,000 persons who did not have status but who reported as being Indians.[2]

Within two generations, the population of non-status Indians will likely increase over and above simple population growth. Inheritance of status under Bill C-31 is dependent on the status of parents and grandparents. This means that after two generations of out-marriage (i.e. marriage between a person registered under the *Indian Act* and a non-registered person), off-spring are not entitled to Indian registration. Between 1995 - 2010, children lacking entitlement under the Indian Act are expected to increase from about 10% to 18%.[3]

First Nation

Recently, First Nation has replaced the term "Indian" in general usage. A First Nation community refers to a relatively small group of Aboriginal (i.e. Indian) people residing in a single locality.[4]

In this report, and consistent with common usage, *First Nations* in the context of communities and in health information from First Nations & Inuit Health Branch (FNIHB) of Health Canada means status Indians. In general usage, the term First Nations often denotes all persons of North American Indian ancestry including Indian persons with and without status (such as when the phrase "First Nations, Inuit and Métis" is used to represent all Aboriginal groups). For greater clarity, the term *North American Indian* has been used in relevant statistics to describe status and non-status Indians. Similarly, the term *Indian* is used only if it is a part of a direct quotation, in a historical or *Indian Act* context, for example to describe the population of Aboriginal people lacking status ("non-status Indians"). The term "registered Indian" or "status Indian" denotes registration under the *Indian Act*.

Métis

RCAP defines the *Métis* as distinct Aboriginal peoples whose early ancestors were of mixed heritage (either First Nations or Inuit; and European) and who associate themselves with a culture that is distinctly Métis.

Inuit

The *Inuit* are Aboriginal peoples of Northern Canada who share a similar linguistic and cultural heritage.

The Inuit are located mainly in the Northwest Territories and Nunavut, however some Inuit communities also exist south of the 60th parallel, in Northern Quebec and Labrador. The federal government, through FNIHB provides health services to First Nations and Inuit communities outside of NWT and Nunavut. In this report the term, *Inuit communities*, in the phrase First Nations and Inuit communities, means those communities located in Northern Quebec and Labrador. *Inuit* refers to all persons of Inuit heritage, including those in the territories.

Population Characteristics

The 1996 Census reports that there were 799,010 Aboriginal people in Canada, or about 3% of the Canadian population. Of this total, approximately 69% reported being North American Indian (554,000), 26% Métis (210,000) and 5% Inuit (41,000).[5] For various reasons, there are at least three sources of population figures available for Aboriginal groups (Canadian census, Aboriginal Peoples Survey, Indian Register), each with limitations in reporting and coverage. Using 1991 census data, RCAP estimated the non-status Indian population to be 20.4% of the total Aboriginal population in 1991 and the status Indian population to be 60.8%.[6] According to the Indian Register of the Department of Indian Affairs and Northern Development (DIAND), in 1997 58% of status Indians were reported to live in First Nations communities.[7]

Limitations of census data

The variations in population figures for Aboriginal people stem from differences in survey questions and variations in coverage, the latter as some First Nations communities choose not to participate in the Census or Aboriginal Peoples Survey (APS) data collection and some communities were incompletely enumerated. In 1991, the Canadian census reported a figure of just over 1 million for the Aboriginal population, based on a question about *cultural origins or ancestry*, whereas the APS, also in 1991, focussed on those persons who *identified* with their Aboriginal ancestry. After adjusting for under coverage, this APS population number was estimated to be 720,000.[8]

In 1996, the Canadian census, rather than only asking about cultural origins or ancestry, included a new question which directly asked if the person was an Aboriginal person, that is, North American Indian, Métis or Inuit. The resulting population of 799,000 is similar to the APS's adjusted population total from 1991.

The Aboriginal population in 1996 was 10 years younger on average than the general Canadian population, and exhibit a different age distribution profile. The Canadian age distribution has a bulge in the 25 to 49 year old group, where the largest proportion of the population exists. The Aboriginal population is concentrated in the childhood and youth years.

- Children under 15 accounted for 35% of all Aboriginal people in 1996, compared with only 20% of Canada's total population.
- Only 4% of the Aboriginal population was aged 65 or over, compared with 12% of the general population.

In terms of geography, generally only in the north do Aboriginal people make up a significant proportion of the population. In the 1996 census, Inuit constituted 84% of the region which subsequently became Nunavut, and Aboriginal people formed 94% of the total population of northern Saskatchewan (in this context, northern refers to the northern half of the provinces), 45% of northern Manitoba and 41% of northern Quebec. More than four out of every five Aboriginal persons lived west of Quebec.

The Aboriginal population has a higher birth rate than the Canadian population even though it has been declining in recent years. Census data showed that there were 491 Aboriginal children aged under five years for every 1,000 Aboriginal women of childbearing age in 1996, which was about 70% higher than the ratio for the total population. Predicted characteristics of the Aboriginal population include:

- Large increases in the next decade in Aboriginal people aged 15 - 24 years. In ten years (1996 - 2006), this population is expected to grow by 26%.
- The age group 35 - 54 which comprises the majority of the working-age population will increase by 41% by 2006.

Life Expectancy

Life expectancy at birth is considerably lower among Aboriginal people than for the Canadian population. Declining mortality rates for First Nations, the only group where historical data on mortality is available, have suggested that the improvement seen in life expectancy will continue. Life expectancy at birth is projected to increase to about 79 years for First Nations females and about 72 years for First Nations males by the year 2010.[9] This compares to 76.2 years for First Nations females and 69.1 years for First Nations males in 1995.[10] Canadian life expectancy at birth for 1991 was 80.9 years for females and 74.6 years for males (Figure 1).

Figure 1
Estimated Life Expectancy at Birth
Total and Aboriginal Populations, 1991[11]

	Male (years)	Female (years)
Inuit	57.6	68.8
Registered Indians on Reserve	62.0	69.6
Métis	70.4	76.9
Registered Indian non reserve	70.5	77.0
Non-registered Indians	71.4	77.9
Total Aboriginal Population	**67.9**	**75.0**
Canadian	**74.6**	**80.9**

As Figure 1 shows, the Inuit in 1991 continued to have the lowest life expectancy at birth of all Aboriginal people, followed by First Nations living on reserve. A difference of 13.8 years, or 24% existed in 1991 between male Inuit life expectancy and that of non-registered Indian males, the group with the longest life expectancy. Non-registered Indians lag about three years behind the Canadian population.

Even though gains are projected for life expectancy leading to increased numbers of elderly, the Aboriginal population is expected to continue to have a high proportion of young people. This population growth has a number of implications on health services:

- a higher demand for health services which results in more pressure to deliver services in an efficient and cost-effective manner;
- an increased number and cost of chronic conditions (this will be discussed in more detail in the health status section) such as diabetes, high blood pressure, arthritis, and tuberculosis.
- in the First Nations population, an increased demand for services under the federal non-insured health benefits (NIHB) program. This program provides vision, dental, pharmacy and medical transportation benefits to persons registered under the *Indian Act*. Between 1995 - 2010, pharmacy services are estimated to increase by more than 50% in utilization and 56% in expenditures (1995 dollars). For the same period, dental services are projected to increase by 32% in utilization and 37% in expenditures.[12]

National Aboriginal Organizations

Distinct political organizations have evolved in Canada which represent the different Aboriginal groups identified in the *Constitution Act, 1982*. These organizations are important in a health services context as they serve a consultative and advocacy role. Up until fairly recently as will be explained in the section on current federal government initiatives (page 21), the federal government has been primarily concerned with provision of health services to First Nations and Inuit as part of their historical policy position in this area. However, recently a more inclusive pan-Aboriginal approach to issues concerning the federal government and Aboriginal people has been instituted in some instances. In practical terms, this new approach means that new federal health initiatives directed to all Aboriginal peoples are developed in consultation with the five representative national Aboriginal organizations.

The national Aboriginal organizations are relatively young, having being formed in the last 30 years or less. Part of this relatively late entry into organized advocacy relates to restrictive measures of the *Indian Act*. The 1927 version of the *Indian Act* forbade First Nations people in communities from forming political organizations, as all control was to be vested in the government sanctioned band council system. It was not uncommon for First Nations leaders to be jailed for attempting to organize such a political group. In addition, the *Indian Act* directly attempted to suppress Aboriginal culture, through the banning of potlatch ceremonies and other practices of Aboriginal religion.[13]

On a national level, Aboriginal people in Canada made a number of unsuccessful attempts to organize during this century, starting with the League of Indians in Canada after World War I, the North American Indian Brotherhood in the late 1940s and the National Indian Council which existed from 1961 to 1968. This latter organization was the last attempt to unite different Aboriginal groups into one organization. Quite simply, uniting multiple Aboriginal voices into one organization was a difficult if not impossible goal to sustain.

Assembly of First Nations

The forerunner of the Assembly of First Nations (AFN), the National Indian Brotherhood (NIB), was formed from the disintegration of the National Indian Council. It represented all status Indians including those who negotiated treaties. The NIB gained early legitimacy as one of its first actions was to successfully oppose the federal government's 1969 White Paper which called for the assimilation of First Nations people into the mainstream of Canadian society and the dismantling of DIAND, the main department administering the requirements of the *Indian Act*. A transition from the NIB to the AFN occurred in 1982 in response to a call by First Nations chiefs for a more representative and accountable organization. With this change in structure, First Nations government leaders are able to directly formulate and administer the policies of the AFN.

Today, the AFN is the national representative/lobby organization of the 630 First Nations communities in Canada. The AFN exists to promote the restoration and enhancement of the special relationship between the Crown and First Nations as manifested through treaties and other historical documents. The mission statement of the Health Secretariat of the AFN includes: "We are responsible to protect, maintain, promote, support and advocate for our inherent, treaty and constitutional rights, holistic health and well-being of our nations."

In recent years, the AFN has been more vocal in asserting that it represents all First Nations people, including those which are on band membership lists but reside outside of First Nations territory ("off-reserve"). Services to this off-reserve membership have gained more prominence given the recent Supreme Court decision in the C*orbiere* case. The court ruled that section 77(1) of the *Indian Act*, which states that only members who are "ordinarily resident on the reserve" can vote for chief and council, violates the Canadian Charter of Rights and Freedoms. Currently 274 First Nations exclude non-resident members from participating in elections.[14]

Congress of Aboriginal Peoples

The Congress of Aboriginal Peoples (CAP) was founded in 1971 as the Native Council of Canada. It was established to represent nationally the interests of Métis and non-status Indians, to address the lack of recognition of this population as Aboriginal peoples and to challenge their exclusion from federal responsibility. This mandate has evolved to include off-reserve Indian and Métis peoples regardless of status under the *Indian Act*. This increased inclusivity of all non-reserve peoples has been the result of a number of developments:

- the constitutional recognition of Aboriginal and treaty rights in 1982, which has made common treaty and Aboriginal rights the dominant legally recognized basis for political organization;
- the negotiation of land claims which include all Aboriginal groups defined in Section 35 of the Constitution, not just those which have "status";
- passage of Bill C-31 which greatly increased the number of off-reserve status Indians. Currently, about 92% of reinstated Indians have not returned to reserves, and about 20-30% of these are excluded from band membership;
- the decision of the federal government in 1985 to institute a two-track policy for self-government on and off reserve.[15]

Both CAP and AFN advocate on behalf of off-reserve status Indians, a conflict that has had little real impact to date as self-government and land claims are negotiated with individual groups not national organizations. The federal government views these national organizations as representative of their membership not necessarily as service providers and has included all Aboriginal groups (including the Métis and Inuit) in consultations on recent health program initiatives, therefore there has not been a need to legitimize one particular organization's role in representation of the off-reserve group.

Métis National Council

The Métis National Council (MNC) was established in 1983 as the national voice of the Métis Nation.[16] Its first objective was to ensure that the Métis were represented at the four First Ministers conferences on constitutional and Aboriginal rights which took place in the 1980s. The founding MNC was comprised of the prairie Métis, who separated from the Native Council of Canada, so as to more effectively advocate for specific Métis rights in the Canadian constitution consultations.

The MNC's main goal is to ensure the full participation of the Métis in the process of asserting inherent Aboriginal Métis rights to self-government and self-determination. The MNC is composed of five provincial organizations from British Columbia, Alberta, Saskatchewan, Manitoba and Ontario. The MNC is governed by a Board of Governors made up of the presidents of the provincial associations and the national president.

The Métis have a historical legal basis to land title, stemming from a promised grant of 1.4 million acres of land to the Métis which was negotiated as part of Manitoba's entry into confederation. The subsequent mishandling of this promised land by the federal government through a script system which allowed land speculators to acquire land intended for Métis became one of main catalysts to the 1885 Riel Rebellion.

Inuit Tapirisat of Canada

The Inuit Tapirisat of Canada (ITC) is an advocacy organization dedicated to the needs and aspirations of Inuit. Formed in 1971, it represents more than 40,000 Inuit living in 55 communities in the Northwest Territories, Nunavut, Northern Quebec and Labrador. As the national voice of the Inuit in Canada, it addresses issues of vital importance to the preservation of identity, customs and way of life.

On health matters, the Inuit in the past have often been represented by Pauktuutit, the Inuit women's association. Pauktuutit is an autonomous organization which was created by a resolution of the ITC board in 1984 to deal with social issues. Pauktuutit's mandate is to foster a greater awareness of the needs of Inuit women, and encourage their participation in all levels of social, cultural and economic development. In 1986, the ITC through its involvement with major political and land claim issues, realized that there were numerous social and health issues remaining to be addressed, and formally transferred the organization's health mandate to Pauktuutit. Since that time, Pauktuutit has developed significant expertise in health and is a recognized organization among the Inuit public.

In 1998, ITC reclaimed the health mandate and has increased its role in health policy. Pauktuutit remains involved in health activities on a project level, in areas such as HIV/AIDS, substance abuse, tobacco cessation and fetal alcohol syndrome.

Native Women's Association of Canada

The Native Women's Association of Canada (NWAC) gained recognition by the federal government during the 1980s constitutional talks when it was clear that the rights of Aboriginal women needed a separate voice in discussions on Aboriginal rights and self-government. Currently, NWAC has a small national secretariat.

A sixth national organization, the National Association of Friendship Centres (NAFC) is sometimes included in federal consultations. This is in recognition of the significant role NAFC plays in providing services to all Aboriginal people, regardless of group or status, who live in an urban environment, and in supporting self-determined activities which encourage equal access to, and participation in, Canadian society.

Health Status of Aboriginal Peoples

Decline in Aboriginal Health

There is abundant historical documented evidence to support the fact that before the influx of Europeans in North America, indigenous peoples were of excellent health and strong physique. These accounts, from explorers and traders, proclaimed the health and vigour of the Aboriginal people they met and their amazement at the feats of strength and physical endurance. These peoples were spared from most of the infections, deficiencies and degenerative diseases that found their way into Aboriginal society post European contact.[17]

The effects of European contact on the continent's original inhabitants were many-fold and remain a profound indictment of western civilization's adverse impact on Aboriginal health and well-being. These include[18]:

- transmission of infectious diseases, such as small pox, measles, mumps and influenza into widespread epidemics. This transmission was sometimes facilitated by the deliberate distribution of disease-ridden blankets and other "infectious gifts";
- the inability of the skilled medicine men to correctly treat these new diseases, as infectious diseases in general were largely unknown;
- the reduced resistance to infection seen in Aboriginal people who had prolonged contact with Europeans (elaborated in the next points). Historical records confirm that infectious diseases alone did not cause the extreme decimation of the Aboriginal population, rather these occurred in the greatest numbers after long contact with Europeans;
- the establishment of trading with Aboriginal people which introduced store bought items into their diet, and encouraged hunting beyond subsistence needs. This in turn caused traditional hunting patterns to be abandoned in order to pursue the fur trade, leading to food shortages and even starvation;
- resource deprivation caused by over hunting and fishing resulting in a loss of trading leverage for commercial foods and subsequent malnutrition;
- degeneration of the Aboriginal diet to one increasingly devoid of protein and other nutrients, and characterized by refined carbohydrates. It was far easier to ship white sugar and white flour to Aboriginal settlements than foods of greater nutritional value;
- confinement to a reserve and incompatibility of Aboriginal peoples' existing sanitation customs (which were based on a nomadic way of life) with permanent residence in one area;
- devaluation and suppression of traditional Aboriginal medicine concurrent with the spread of Christianity;
- development of the residential school system. The schools became deadly sites for the spread of tuberculosis, with mortality rates of 25% and higher. If children survived TB, they were likely to become victims of mental, physical and sexual abuse in the schools. Overall, the residential school experience is blamed for much of the breakdown of traditions, cohesion and family bonding in Aboriginal life.

In the federal government's *Statement of Reconciliation to Aboriginal People*, this past was acknowledged. Part of the Statement includes:

> "As a country we are burdened by past actions that resulted in weakening the identity of Aboriginal peoples, suppressing their language and cultures, and outlawing spiritual practices. We must recognize the impact of these actions on the once self-sustaining nations that were disaggregated, disrupted, limited or even destroyed by the dispossession of traditional territory, by the relocation of Aboriginal people, and by some provisions of the *Indian Act*. We must acknowledge that the result of these actions was the erosion of the political, economic and social systems of Aboriginal people and nations."[19]

Appendix 1 provides an overview of the evolution of health services to First Nations and Inuit, services which were provided by FNIHB to those individuals living on reserve and in northern locations. Initially, communities were dependent on health professionals employed by the federal government and the health programs they implemented. However, in the past 20 years, communities have assumed increasing control of health and social services through contribution agreements, health transfer arrangements and self-government.

Health Status Today

Throughout the 20th century, Aboriginal people have continued to experience poor health status and live in conditions of poverty, low education, and low employment. Up until 1991, most health and social information was available only for status Indians and Inuit who lived on reserve or in Inuit communities and were recipients of services provided by FNIHB and DIAND. Basic records were kept on this population such as mortality, housing conditions, educational attainment and dependence on social assistance. The limitations of this fairly standard socio-economic data collection should be acknowledged, as it reflects a western scientific and academic approach on the measurement of socio-economic perspectives, and as such does not necessarily include Aboriginal interpretations of human development and wholeness.

In 1991, the APS was conducted, a post-census survey directed to all Aboriginal people in Canada which has provided benchmark population, health and social data for Métis, Inuit as well as North American Indians (on and off reserve). The APS showed that health status for Métis and urban Aboriginal populations, while slightly improved from that seen in First Nations and Inuit communities, was still significantly poorer than the health of other Canadians. Furthermore, Métis, Inuit and North American Indians illustrate a similar pattern of health status for many health indicators.

RCAP pointed to the following facts regarding Aboriginal health, which are described more fully in this section:

- Differences in life expectancy can partially be attributed to high rates of infant mortality, for which data exists among First Nations peoples. Mortality for all age groups is higher for First Nations than for Canadians generally;

- Aboriginal people have higher rates of infectious diseases;
- The Aboriginal population, which previously had little experience with life-threatening degenerative conditions, is now experiencing increasing rates of cancer, heart, liver and lung disease;
- Overall rates of injury, violence and self-destructive behaviour are disturbingly high;
- Rates of overcrowding, educational failure, unemployment, welfare dependency, conflict with the law and incarceration all point to major imbalances in the social conditions which shape the well-being of Aboriginal people.[20]

Socio-Economic Conditions

Figure 2 illustrates data from the APS, the 1991 Canadian Census and DIAND which together provide a comparative snapshot of socio-economic conditions among Aboriginal people in the early 1990s.[21]

Figure 2
Selected Socio-Economic Indicators
Aboriginal and Non Aboriginal Populations, 1991

	Aboriginal Population	**Non Aboriginal Population**
Unemployment rate	24.6 % (range 21.1% non-status to 30.1% First Nations [FN] on reserve)	9.9%
Median Family Income	$26,295 (FN only)	$36,461
% income from government transfer payments	23.3% (range 28.5% FN on reserve to 14.8% non status)	11.4%
% receiving social assistance	28.6% (range from 41.5% FN on reserve to 22.1% Métis)	8.1%
Dwellings with no central heating	12.5%	3.6%
Dwellings without piped water	9.4%	0.1%
Average # persons per dwelling	3.5	2.7
Less than a grade 9 education	24.0% (rises to 27.9% for FN on reserve)	13.8%
University degree	2.6%	11.6%

These selected socio-economic indicators show that in all areas from employment, earned income, and housing conditions to education, Aboriginal people rate significantly lower than the rest of the population. For example, when considering First Nations persons living on reserve, unemployment was three times greater than other Canadians in 1991. There are many barriers to economic development in Aboriginal communities, including failure to access capital due to lack of equity and lack of collateral (section 89 of the *Indian Act* restricts bands and individuals on reserve from pledging real and personal property on a reserve as security for commercial loans), few individuals with business and financial skills, cultural issues which may prevent significant development of resources (forestry is one example), and the location of most communities on small pieces of land which have poor agricultural development potential, and may be isolated or located at substantial distances from urban service centres.[22] Although this list of issues and barriers was developed for the situation of First Nations communities, other indicators from the APS in Figure 2 which provide information on all Aboriginal groups compared to the non-Aboriginal population in 1991, show that this discouraging economic situation is shared by all Aboriginal populations:

- Aboriginal people in 1991 were 3.5 times more likely to be on social assistance. than non-Aboriginal Canadians. This rises to a more than 5 fold difference when considering only First Nations people;
- The rate of dwellings without piped water was 90 times greater in the Aboriginal population;
- On average, 30% more Aboriginal people lived in a single dwelling compared to non-Aboriginal people;
- Almost two times more Aboriginal people lacked a grade 9 education.

Mortality Rates

Provincial and territorial health information systems do not record ethnic information on death certificates, therefore the only source of mortality rates for Aboriginal people concern those of First Nations. FNIHB, which collects this information, obtains it from either health workers in individual First Nations communities (on reserve members only) or from the provincial/territorial databases (on and off reserve) in the four western provinces and the Yukon. Mortality rates for First Nations have declined by 21% from 1979 to 1993. The Canadian population has also experienced a downward trend, with the result that the gap between the First Nations and Canadian populations has persisted. In 1993, age standardized mortality rates were 10.8 deaths per 1,000 for First Nations and 6.9 deaths per 1,000 for the Canadian population. In 1991- 1993, the leading causes of First Nations mortality were injury and poisoning, circulatory diseases, neoplasms and respiratory diseases.[23]

The First Nations infant mortality rate similarly has shown improvements (a decline of 60% from 1979 to 1993). Although the gap compared to the Canadian population was smaller than it was in 1979, the infant mortality rate (10.9 deaths per 1,000) remained 1.7 times the Canadian rate in 1993. When the First Nations infant mortality rate is separated between neonatal (1-28 days of age) and post-neonatal (28 days to 1 year of age), an influence of socio-economic conditions is apparent. The First Nations neonatal rate, considered to be more responsive to access and quality of health care, is similar to that of the Canadian population. The First Nations post-neonatal rate, a more sensitive barometer of the impact of socio-economic factors which may influence infant survival, has remained three times the Canadian rate from 1979 to 1993.[24]

The causes of infant mortality among First Nations in the years 1989 - 1993 included sudden infant death syndrome (26.9%), respiratory conditions (6.6%), injury and poisoning (6.9%) and congenital anomalies (18.8%).[25]

Injury is a significant cause of childhood mortality among First Nations. In 1993, this rate was five times greater than the Canadian rate for pre-schoolers, almost four times greater for children overall, and more than three times greater for teenagers.[26]

Morbidity

It has been well documented that Aboriginal peoples have experienced an epidemiologic transition in the 20th century from diseases primarily associated with infectious agents to chronic diseases which are prevalent in western civilization. Infectious agents are still a significant cause of Aboriginal morbidity, particularly in tuberculosis, hepatitis, gastroenteritis, meningitis, sexually transmitted diseases, chronic ear infections and acute respiratory infections. In almost all categories of infectious diseases, Aboriginal rates are higher, and may approach a5 fold for TB.[27] Hypothesized reasons for these increased rates of illness include poverty, community dysfunction and poor self-esteem, overcrowding, inadequate heating, environmental pollutants and an inadequate diet.

Tuberculosis among Aboriginal people has been resistant to eradication strategies that have served the general population well. From 1996-1998, the tuberculosis rate (number of cases per 100,000 three year moving average) was 1.6 among non-Aboriginal, Canadian-born citizens. This rate rose to 23.5 in the Aboriginal populations, or 39.7 among First Nations (a 25 fold difference compared to non-Aboriginal Canadian-born citizens).[28] Although still high, these rates have greatly diminished over the last 40 years. Recently this improvement has stalled, prompting renewed concern and strategies to combat this disease. A National Consensus Conference on Tuberculosis regarding Aboriginal Issues has developed a series of ten recommendations including partnerships between government authorities and health authorities of Aboriginal peoples, culturally-sensitive materials, training, and education, a centralized surveillance system and other activities.

HIV infection in First Nations, Inuit and Métis populations will be covered in the section on HIV/AIDS epidemiology in Part II of this report.

Chronic Diseases

The first substantive look at the prevalence of chronic diseases in the entire Aboriginal population was provided by the APS which found the prevalence of diabetes, hypertension, arthritis/rheumatism, heart problems, bronchitis, and asthma among First Nations, Métis and Inuit to be comparable or greater than that in the Canadian population. Chronic diseases have been associated with a lifestyle of modern industrial nations, one where regular exercise is diminished, high levels of stress are common, diets are high in sugar, fat and caffeine and air and water borne pollutants exist. Tobacco smoking is at a crisis level among Aboriginal peoples, and at 62% for First Nations on reserve in 1997, it is double the rate of Canadians obtained in the National Population Health Survey. Rates of smoking among First Nations under 30 years are over 70%.[29]

The First Nations and Inuit Regional Health Survey (FNIRHS) which was conducted in 1997 confirmed the seriousness of chronic diseases among First Nations and Inuit communities, and showed that the rates had increased in this population since the APS six years earlier. There is no recent information available to determine whether chronic diseases are also increasing in the Métis, Inuit and First Nations off-reserve populations. The next APS is planned for 2001, which will provide needed longitudinal data in this area for all Aboriginal groups.

In the FNIRHS, the First Nations/Canada ratio of age-adjusted prevalence for diabetes was 3.3 (males) and 5.3 (females); for heart problems was 3.0 (males) and 2.9 (females); for cancer was 2.0 (males) and 1.6 (females), for hypertension was 2.8 (males) and 2.5 (females); and for arthritis/rheumatism was 1.7 (males) and 1.6 (females). Chronic diseases are associated with significant disability in terms of activity limitation, needing help with personal care, and being house bound. In the FNIRHS, individuals with chronic diseases were more likely to report being in poor health and to mention the need for more health services and facilities.[30]

Diabetes is an increasingly critical issue among Aboriginal people. Complications include renal impairment leading to end-stage renal disease, vision loss, amputations, cardiovascular conditions and premature death. These complications affect Aboriginal people earlier in life and are often of a greater severity. Ninety percent of diabetes in the Aboriginal population is Type 2 which is associated with a sedentary lifestyle and a diet high in carbohydrates.

Community and Individual Wellness

Given the adverse circumstances faced by many Aboriginal people in finding employment, achieving a higher education and improving their living conditions, it should not be surprising that suicide, substance abuse and violence are realities in many Aboriginal communities. Figure 3 data has been obtained from the APS and looks at the perception of Aboriginal people regarding social problems facing communities.

The two issues which were rated as the highest social concerns by all Aboriginal groups were unemployment and alcohol abuse, both of which chosen by greater than half of all survey groups. Alcohol abuse is related to another serious concern among Aboriginal communities, fetal alcohol syndrome and fetal alcohol effect (FAS/FAE). The exact prevalence of FAS/FAE in communities is unconfirmed, as research studies have provided conflicting results on prevalence rates, however there is general agreement that this issue is a major problem and must be addressed, as children can suffer from major learning and socializing problems. The 1999 federal budget has included resources directed to FAS/FAE.

In the APS, drug abuse and family violence were rated as concerns by 47.2% and 39.2% of all respondents respectively (Figure 3). The two groups associated with distinct non-urban communities (North American Indian on reserve and Inuit) consistently had the highest responses for all social concerns in Figure 3, and confirm the serious problems facing these communities.

Figure 3
Percentage of people reporting social issues as concerns in the community where they live, Aboriginal People Survey[31]

Social Issue	North American Indian People on Reserve	North American Indian People off Reserve	Métis People	Inuit	All Aboriginal People (n=388,900)
Suicide	34.5	20.4	21.6	41.2	25.2
Unemployment	78.3	60.2	74.5	74.5	76.1
Family Violence	44.1	36.4	39.0	43.5	39.2
Sexual Abuse	29.0	21.8	23.0	35.1	24.5
Drug Abuse	58.8	43.2	45.2	49.0	47.9
Alcohol Abuse	73.3	56.0	58.8	57.6	61.1
Rape	16.4	13.3	14.6	24.9	14.9

The FNIRHS in 1997 looked at community wellness from another perspective, by asking respondents the question: do you think a return to traditional ways is a good idea for promoting community wellness? This was answered affirmatively by over 80% of respondents. Respondents were also asked to rate the progress of different community wellness factors. Although a minority thought that there was good progress in wellness factors, at least 72% of respondents indicated that there had been *some level* of progress in the last two years in the following wellness factors: cultural programs in schools, education and training opportunities, water and sewage facilities, use of elders, control of programs by First Nations, traditional ceremonial activities, return to traditional ways and the use of First Nation/Inuit languages. Over 50% of all respondents saw progress in all rated factors except reduction in alcohol and drug abuse.[32]

Rights and Responsibilities

The First Peoples of Canada have a long history of agreements first with the British Crown, and later with the Canadian government, the latter of which Aboriginal people have interpreted as acting on behalf of the Crown. The first agreement, the Two Row Wampum, was negotiated in the 1600s and is a lasting record of British government's recognition of the nationhood of the Five Nations Confederacy, who negotiated this treaty with Britain.

A primary purpose of the *Royal Proclamation* of 1763 was to lay the framework for the negotiation of treaties which subsequently cleared lands of Indian title. The Proclamation has been interpreted by the federal government as acknowledging a fiduciary relationship to Aboriginal people. Aboriginal groups see it more broadly as also confirming a nation-to-nation relationship. The Proclamation stands to this day as one of the main European historical records referenced in discussions on Aboriginal and treaty rights.

Canada's founding legislation, the *BNA Act, 1867*, essentially transferred the British Crown's responsibilities regarding Aboriginal people to Canada. This was followed by the *Indian Act, 1876* which described these federal responsibilities and began the Indian registration system within the Aboriginal population which exists to this day. Two classes of Aboriginal people resulted from the *Indian Act*: those who were entitled to special rights and considerations from the Canadian government[33] and those who missed being included or were denied status for reasons such as marriage to a non-Indian man or enfranchisement. Joining the miliary or voting in a Canadian election were two common reasons for enfranchisement. The effect of this status structure on the delivery health services, to be discussed in the Critical Issues section of Part II of this report, revolves around jurisdictional claims of federal and provincial governments regarding where responsibility for status Indians and Inuit reside.

Aboriginal Rights and Fiduciary Responsibilities

Since the historic inclusion of all Aboriginal people in the C*onstitution Act, 1982*, more clarity has been provided in what Aboriginal rights entails, what the federal government's responsibilities include and how treaties should be interpreted. Section 35 states:

1. The existing aboriginal and treaty rights of the aboriginal people of Canada are hereby recognized and confirmed.
2. In this Act, "aboriginal peoples of Canada" include the Inuit, Indian and Métis peoples of Canada.

Much of the clarity has been obtained from court judgements, as the constitutionally mandated conferences on Aboriginal rights which took place in the 1980s did not achieve any agreement on this topic. The courts have described a fiduciary relationship between Aboriginal peoples and the government. The court decision in *Guerin* emphasized that the fiduciary obligation owed by the Crown was *sui generis* or unique[34]. There are three general principles of fiduciary law which must be met in order to prove a fiduciary relationship: (1) there is an obligation to act on behalf of the principal, (2) there is a power to affect the principal's legal interests, and (3) the principal exists a vulnerability to the exercise of that power.[35] The court in *Guerin* have described this relationship:

> "The fiduciary relationship between the Crown and the Indians has its roots in the concept of aboriginal, native or Indian title. The fact that Indian Bands have a certain interest in lands does not, however, in itself give rise to a fiduciary relationship between the Indians and the Crown. The conclusion that the Crown is fiduciary depends upon the further proposition that the Indian interest in the land is inalienable except upon surrender to the Crown"[36]

Space does not permit a thorough review of relevant court decisions on the issue of fiduciary obligations and Aboriginal rights. Fiduciary obligations are triggered by government action when it concerns Aboriginal rights, title and perhaps even Aboriginal interests. The nature of a fiduciary obligation has been interpreted to encompass a wide scope of issues including self-government, Aboriginal title, compensation for breach of faith, duty to consult and the principle of partnership.[37] Fiduciary responsibility cannot be overridden based on other priorities or considerations[38] and government actions cannot be unreasonable or create undue hardship. With respect to health, the federal government recognizes it has a special relationship with First Nations and Inuit which may give rise to a fiduciary responsibility under certain circumstances. It has indicated that it is committed to assisting First Nations and Inuit communities to address health inequalities and disease threats.

The *Sparrow* decision interpreted section 35 (1) of the Constitution in the context of fiduciary responsibility, as it ruled that "the words recognition and affirmation incorporate the fiduciary relationship. . . and so import some restraint on the exercise of fiduciary power."[39] It therefore expanded the application of fiduciary responsibility from the surrender scenario of *Guerin* to constitutionally protected Aboriginal and treaty rights.

Fiduciary obligations are the same regardless of the group of Aboriginal people involved. Both general fiduciary obligations and those obligations relating to section 35 Aboriginal rights can be owed to all groups of Aboriginal peoples. Similarly, the nature of these obligations that are owed need not favour one group over another except in particular defined situations and by reference to facts in hand.[40]

Fiduciary obligations are not the exclusive domain of federal governments. There may be situations where a provincial government has an obligation to act on behalf of an Aboriginal group, and if this discretion affects their legal interests and causes the Aboriginal group to be vulnerable to the exercise of this jurisdiction, then the principles of fiduciary obligation apply.[41]

The courts have ruled that there is a duty of the federal government to consult in any situations where Aboriginal or treaty rights may be infringed.[42] Legal opinion has suggested that this duty may be directed to provincial governments as well, as they have the constitutional responsibility for certain services, and thereby would be accountable for any actions that may interfere with an existing Aboriginal right.[43]

Treaty Rights

Whether or not a treaty right to health care exists is a point of dispute between the federal government and First Nations. Although there is a reference to specific health measures in one treaty and reference to pestilence or medical services were included in a minority of treaties or treaty discussions,[44] the federal government does not regard these as promising entitlement to general health services. History has recorded Lieutenant-Governor Alexander Morris, who negotiated treaties on behalf of the Crown, as promising the Crees that it was the Queen's way to provide relief in the case of national famine and medical care in the case of national pestilence. Governor Morris went on to assure the Crees that writing appropriate provisions in a treaty would not affect these policies.[45] (Recently, courts have upheld the validity of oral records as evidence in determining Aboriginal rights in areas other than health, but this particular verbal promise has never been tested in the courts.)

Treaty #6 which was negotiated with the Cree Chiefs for part of present day Saskatchewan and Alberta was the only treaty which included a reference to certain health services:

> "That a medicine chest will be kept at the house of the Indian Agent for the use and benefit of the Indians at the direction of such Agent."

First Nations assert that a contemporary, broad definition of medicine chest and pestilence should be used, since when the treaties were signed, this terminology was appropriate and sufficient to record the health services needed to meet the health needs of Aboriginal people. The Supreme Court has not interpreted treaties in a health context, however the position of the federal government has always been that it has provided health services to First Nations and Inuit as a matter of policy, not legislative or treaty responsibility. This stems from its unique relationship with First Nations and Inuit, arising from the *Indian Act*, the treaties, and its historical policy of providing community health services to reserves and northern communities.

Self-Government

Self-determination and self-government are often used interchangeably in discussions on Aboriginal rights. The federal government has recognized the inherent right to self-government as a section 35 right in the Constitution, with the exercise of that right falling under the Canadian framework. RCAP has described self-government in the context of self-determination. RCAP views self-determination as a right of all First Nations, Inuit and Metis peoples of Canada which is founded in emerging norms of international law and basic principles of public morality. Through the principle of self-determination, Aboriginal people are able to negotiate with the Canadian government on governmental structures that they consider appropriate for their needs. At the same time, Aboriginal people have an inherent right to self-government from their original status as sovereign nations who negotiated alliances and treaties with other sovereign nations. Therefore from RCAP's perspective, self-government is in essence a tool which can be used by a people to exercise their right to self-determination.[46]

Self-government can encompass more than simply a transfer of responsibility for the resource allocation and delivery of health services; it may represent a type of government which is based on traditional norms and values not present in the Canadian system. Through self-government, Aboriginal people can assume their right to incorporate traditional systems within the Canadian framework, and in the case of the health system, to fully control the planning and delivery of health services to their population.

It is conceivable that new models of governance may be founded on Aboriginal practices when planning self-government if a community desires a return to traditional ways. For example, the new government of Nunavut operates on a consensus basis, and does not have a political party system. Certainly with respect to health care, some communities may wish to provide certain traditional practices, although these practices would likely be an addition to the existing system for people who requested them, not a replacement. The FNIRHS specifically asked First Nations and Inuit respondents whether a return to traditional ways was a good idea for promoting community wellness. A large majority of respondents answered yes, they wanted a different paradigm or model of heath care which is based on traditional ways, and where wellness is interpreted more holistically than the dominant Eurocentric bio-medical view.[47] The survey did not define what traditional ways meant, or indeed what constituted community wellness but this result seems to suggest a lack of confidence of First Nations and Inuit respondents on the ability of the current health system to restore community well-being and individual health.

Although self-government may be most easily visualized in a reserve or defined land environment, self-government processes for Métis and off-reserve Aboriginal groups are being negotiated, and can include self-government institutions, devolution of programs and services, and public government.[48]

The role of national Aboriginal organizations, such as the AFN, CAP, MNC and ITC is primarily in the development of frameworks to negotiate self-government and in advocacy as the federal government generally negotiates directly with individual groups. A potential area where national Aboriginal organizations can provide a vital supportive role to self-governing entities concerning HIV/AIDS might be in national policy leadership, for example, in developing policies preventing discrimination of community members based on HIV status, in advocating for equity in resource allocation based on need and in participating in the resolution of jurisdictional issues which create barriers to care.

Current Federal Government Initiatives in Aboriginal Health

Overview

The federal government's policy relationship with Aboriginal groups has seen significant change in the last decade. As little as fifteen years ago, federal Aboriginal resources for health and social programs were directed almost exclusively to First Nations and Inuit populations; non-reserve groups received limited programs from the federal government (examples would be the off-reserve housing program and the Canadian Aboriginal Economic Development Strategy), and indeed these groups were virtually invisible to the Canadian public. Although the constitutional talks which involved Metis, Inuit and First Nations did sensitize the governments in these negotiations to the differences of these populations, the Canadian media's desire to neatly package the complex range of issues as merely "Aboriginal" and to feature the AFN as the voice of all Aboriginal issues, created an image of a homogeneous Aboriginal population.[49] Today, the federal government's policy focus remains primarily directed to First Nations and Inuit, however several new pan-Aboriginal health initiatives exist (e.g. Organization for the Advancement of Aboriginal Peoples' Health [OAAPH], Aboriginal Diabetes Initiative, Aboriginal Healing Foundation, Aboriginal Head Start) which involve the non-status, off-reserve and Métis populations. The following events of the 1990s provide a contextual basis for the current federal initiatives in Aboriginal health:

- *the recognition of the inherent right to self-government.* Although the 1992 Charlottetown Accord failed in a public plebiscite, one of the most debated aspects of the this draft agreement was a section recognizing self-government of Aboriginal peoples. The Accord was rejected for numerous reasons, not merely self-government, however the public discussion which this topic engendered showed the receptivity of the Canadian population to Aboriginal self-government aspirations. In 1995, the federal government unilaterally recognized the inherent right to self-government for First Nations, Metis and Inuit as an existing Aboriginal right within section 35 of the *Constitution Act, 1982.* This has acted as an impetus to the establishment of more than 80 self-government tables by 1999[50], and has further supported the devolution of responsibility and resources to Aboriginal organizations, including those related to health services;

- *clarification by the courts, including the Supreme Court of Canada, on the determination of existing Aboriginal rights and the fiduciary responsibilities of the federal government.* As discussed above, the courts have ruled that this fiduciary responsibility extends past First Nations and Inuit, the two groups which have historically benefited from federal programs and services, to include Metis and non-status groups;

- *the release in 1996 of RCAP's long awaited, five volume response to address the many problems and issues facing Aboriginal people in Canada.* The health directions from RCAP are summarized below. The government responded with its own comprehensive action plan, *Gathering Strength*, also outlined below.

Taken together, the RCAP report and *Gathering Strength* have been credited as the driving forces in the federal government's investment in several pan-Aboriginal health initiatives;[51]

- *the courts' rulings that include a requirement for effective consultation of the federal government with Aboriginal groups when changing programs or services which have an effect on the Aboriginal population*. Recent federal activities in Aboriginal health include participation by the five national Aboriginal organizations on joint steering committees (e.g. in the development of the OAAPH, national Aboriginal diabetes consultation). Aboriginal representation to provide Aboriginal perspectives has also been sought in working groups or committees on programming targeted to the Canadian population (e.g. National Children's Agenda). The importance of court rulings elucidating fiduciary responsibility and the duty to consult, on new federal activities which involve all Aboriginal groups is a matter of speculation; more importance has been attributed to the strength of lobbying by Aboriginal organizations over time, the recommendations of the RCAP report, and the subsequent response by the federal government;[52]
- *the increasing capacity of First Nations and Inuit communities to plan, administer and control health and social programs and services*. This has been combined with the federal government's desire to remove itself from the direct service delivery business. In the case of FNIHB, its residual role or ongoing responsibilities after all programs and services eligible for Health Transfer have been transferred to community control, is now being discussed;
- *the move to health system renewal, particularly in the face of continuing poor health status of Aboriginal people, and the sometimes profound changes to provincial health systems*. For example, the redirection of provincial institutional expenditures to community-based programming such as home care has resulted in a jurisdictional cost-shifting to the federal government, as provinces have not assumed responsibility for home care to reserve-based First Nations and Inuit communities. In recognition of this service gap and the great health needs of First Nations and Inuit, a First Nations and Inuit Home and Community Care Program was announced in the 1999 federal budget. This and other initiatives relating to health system renewal are discussed below.

RCAP: Nation to Nation; People to People

The socio-economic, health and other problems facing First Nations, Metis and Inuit were considered holistically in RCAP's agenda for fundamental change which included self-government, economic self-reliance, a partnership of mutual respect for Canada, and healing in the broadest sense.[53] The commissioners' recommendations on social and health policy focussed on three objectives seen as interlinked: solving urgent health and social problems, promoting human capacity building in Aboriginal nations, and alerting mainstream institutions of their responsibilities to Aboriginal people.

The recommended strategy for health and healing was to be founded on a commitment from federal, provincial, territorial and Aboriginal governments to build health and healing systems which would accomplish the following:

- pass the levers of control to Aboriginal people;
- take a holistic approach to personal and social health;
- provide diverse services that respond to the cultures and priorities of Aboriginal people and to the special dynamics of Aboriginal ill health; and
- bring equality in health status to Aboriginal people.

Gathering Strength: A Government Perspective

Current federal policy and initiatives in Aboriginal issues are consistent with *Gathering Strength*, the federal response to the RCAP report which was announced early in 1998. *Gathering Strength* clearly placed partnership with Aboriginal groups and development of self-government as pivotal components in a new federal/Aboriginal policy era. Key themes in this federal approach are:

Partnerships: involving the federal government, Aboriginal organizations, and where appropriate, provincial and territorial governments. These working partnerships address needed reforms, through reconciliation and healing, and joint effort on program design and implementation;

Aboriginal governance: create governments, affirm treaty relationships, negotiate land claims. The objective of this theme is to strengthen Aboriginal partners' skills in self-government by negotiating new government-to-government relationships, supporting capacity and professional development, and the delivery of programs to Aboriginal people;

Fiscal relationships: development of stable, predictable, and accountable financial agreements with Aboriginal governments and organizations;

Supporting Aboriginal people, communities and economies: improve health and public safety, invest in people, strengthen Aboriginal economic development. This is will be achieved through fostering and promoting adequate community infrastructure, a skilled workforce, strong and fiscally accountable governance structures and a stable business climate;

Action plans or accords have been separately struck with the AFN, ITC, MNC and CAP regarding the process of implementing *Gathering Strength* and addressing Aboriginal priorities. In its one year progress report, *Gathering Strength* achievements related to the health area include the creation of the Aboriginal Healing Foundation, the Government of Canada's Statement of Reconciliation, capacity development in self-government and the administration of programs, the Aboriginal Human Resource Development Strategy, education reform projects, expansion of Aboriginal Head Start to on-reserve communities, and continuing development of the OAAPH.

Health Initiatives

The following are major health and health-related initiatives of the federal government which are directed to First Nations, Inuit and Metis.

Aboriginal Healing Foundation

A cornerstone of the *Gathering Strength* initiative was the federal government's commitment of $350 million to support community-based healing initiatives for Aboriginal people, on and off reserve, who have been affected by the legacy of physical and sexual abuse that occurred in residential schools. The Aboriginal Healing Foundation was formed in 1998 with the responsibility of allocating these funds. The Foundation's mission is to encourage and support Aboriginal people in building and reinforcing sustainable healing processes that address this legacy.

The Foundation has four years (until 2003) to allocate or commit these resources to Aboriginal communities. Resources provided by the Foundation cannot duplicate existing services or programs. Project proposals undergo a rigorous merit review process which assesses both the methodological merit of the project and its potential impact in addressing sustained healing and building capacity in the community.

In its first year of operation, the Foundation received 1,000 project proposals as well as an additional 1,268 requests for assistance in developing proposals.[54] By the spring of 2000, it had approved 203 projects with a total amount committed of $40.2 million, and a further 37 projects were pending, valued at $4.9 million.[55]

Organization for the Advancement of Aboriginal Peoples' Health

One of the recommendations of the final reports of the National Forum on Health and RCAP concerned the formation of an Aboriginal health institute to address in a coherent, evidence-based way, central issues affecting Aboriginal health. The federal government responded to this call in February 1997 with the announcement of a four year, $20 million commitment to such an institute.

A steering committee, made up of AFN, CAP, ITC, MNC and NWAC conducted extensive consultations with their respective Aboriginal constituencies to obtain input on the potential activities and structure of an Aboriginal health institute. This organization was incorporated as the Organization for the Advancement of Aboriginal Peoples' Health on March 10, 2000 with the following objectives:

- "improving and promoting through knowledge-based activities of Aboriginal Peoples and communities;

- promoting health issues pertaining to Aboriginal Peoples;
- facilitating and promoting research and developing research partnerships relating to health issues;
- fostering the recruitment, training and utilization of Aboriginal People in the delivery of health and healing; and
- affirming Aboriginal traditional healing practices through validating holistic traditional practices and medicines and ensuring such practices receive recognition."[56]

This organization will focus on the development of partnerships with existing programs to advance its agenda of the promotion and improvement of Aboriginal peoples health, and will accommodate three Centres for Inuit, Metis and First Nations health issues. It will not provide funding for health research, directly deliver health services or duplicate any existing programs. The organization will receive ongoing funding at $5 million per year, after initial allocations of $3.55 million, $7.3 million and $7.5 million in its first three years.

Aboriginal Diabetes Initiative

The 1999 federal budget included a commitment of $55 million over three years for a Canadian Diabetes Prevention and Control Strategy. In the following November this amount was increased to $115 million over five years. As the above section on health status has pointed out, diabetes is an increasingly critical issue among Aboriginal people. This is reflected in the strategy which is comprised of two components, one directed to the general population and the other specifically for Aboriginal communities. The Aboriginal Diabetes Initiative will receive $58 million over five years, with $2 million in 1999/2000, $11 million in 2000/01 and $15 million for each of the next three years.

As with the consultations on an Aboriginal health institute, a joint steering committee of Aboriginal organizations was formed in January, 1999. The same five national Aboriginal organizations were provided with resources to conduct community level consultations on the priorities and activities of a national Aboriginal diabetes initiative. As a result of these consultations, the Aboriginal Diabetes Initiative has been designed to include three components: care, treatment and support; diabetes prevention and promotion; and lifestyle support. The First Nations and Inuit portion of the Initiative will cover all three components at 75% of the allocated funds, and remaining 25% will be utilized to address prevention and promotion activities in the off-reserve, non-status and Metis populations.

Program delivery will be initiated in the fiscal year 2000/01. It is expected that $10.5 million of the $11 million for this year will be allocated under contribution agreements. Regional implementation meetings are in progress and are evaluating two potential strategies for a program framework: a strategic priorities approach (such as a network of diabetes education workers in communities) versus proposal-driven funding for community-based activities.

First Nations and Inuit Home and Community Care

The federal government's home care initiative is specific to First Nations and Inuit communities. Home care is not covered under the *Canada Health Act 1984*, and provinces have limited or no involvement in providing home care services to First Nations and Inuit communities, as they see this area as a federal responsibility. The 1999 federal budget contained an amount of $190 million over three years for a home care initiative as well as a First Nations Health Information System (discussed below). The home and community care component has been established at $152 million over three years followed by $90 million ongoing annually. This initiative is now under development, guided by a joint national steering committee made up of First Nations and Inuit representatives as well as FNIHB and DIAND. Resources have been provided in the 2000/01 fiscal year for community-based planning activities.

First Nations Health Information System

The First Nations Health Information System (FNHIS) is an electronic community-based information system which was jointly developed by the Ontario First Nations and FNIHB. It consists of 13 related subsystems dealing with client and community health information which provides information for both client care and the planning, implementation and evaluation of health services. Currently, the FNHIS is operational in 267 health facilities which provide services to 330 First Nations and Inuit communities in the ten provinces. When completely rolled-out, the FNHIS will support 400-450 health facilities representing over 600 communities. Although this system has not been implemented in the territories, interest in the FNHIS has been expressed by the territorial governments.

The federal budget investments over three years will be to complete the roll-out, enhance its capacity and integrate the system with provincial registries, such as chronic communicable diseases. This initiative is now overseen by a joint FNIHB-First Nations steering committee. It is planned that the FNHIS will be transferred to First Nations ownership as of April 1, 2002.

Children's Health Initiatives

The federal government has three principle program areas that address the needs of the Aboriginal population in the children's health area:

- The key on reserve programs include Brighter Futures (which is roughly equivalent to the Community Action Plan for Children or CAPC), Aboriginal Head Start, and the Canada Prenatal Nutrition Program (CPNP) - First Nations and Inuit component.
  - Brighter Futures and CPNP - First Nations and Inuit component funds are managed by FNIHB and are provided to First Nations and Inuit communities through contribution agreements or transfer agreements.[57]

  - Aboriginal Head Start On Reserve Program, an early intervention strategy for First Nations and Inuit children which began in October, 1998 is managed by FNIHB and is provided to successful First Nations on-reserve applicants through contribution agreements.
- Non-reserve programs that include a strong focus on Aboriginal communities are CAPC, CPNP and Aboriginal Head Start.
  - CAPC and CPNP are both federally funded initiatives administered by joint FPT management councils in each province. Projects often combine federal and provincial/territorial funding.
  - Aboriginal Head Start, started in May 1995, is administered by PPHB and is directed to First Nations, Inuit and Métis children living in urban centres and large Northern communities.

CPNP and CAPC were originally funded for a five year period ending in 1997. The benefits of these existing programs were recognized, including the excellent FPT collaborative relationships which have evolved from the administration of these programs. A decision was reached to provide ongoing funding for CAPC and CPNP.

In mid 1997, the FPT Ministerial Council on Social Policy Renewal created a National Children's Agenda (NCA) working group to develop a comprehensive framework for addressing the needs of all children in Canada, including both on and off reserve Aboriginal populations.. An Aboriginal Perspectives sub working group includes representatives from all five national Aboriginal organizations.

The NCA is led by Human Resources Development Canada (HRDC) and Health Canada with collaboration by DIAND and the Department of Justice. The NCA working group model is viewed as a good example of how all Aboriginal stakeholders can be included in a pan-Aboriginal FPT process, however Aboriginal organizations have openly requested a higher level involvement at the ministerial table. Expected outcomes of the NCA include better coordination, information sharing, access to programs and services, identification of gaps, and overall, better outcomes for children, youth and families.

The 1999 federal budget included $75 million over three years for enhancement of CPNP to all Canadians. The allocation of these resources is still to be determined, however it is expected that the allocation to on-reserve CPNP will significantly expand the existing program. As well, a portion of the $75 million will be directed to programs which address FAS/FAE.

Aboriginal Human Resource Development Strategy

The Aboriginal Human Resource Development Strategy (AHRDS) of HRDC is a $1.6 billion, five-year commitment to invest in developing the capacity of Aboriginal organizations to deliver labour market development programs to Aboriginal people. The objective of the AHRDS is to enable Aboriginal organizations to assist clients to prepare for, obtain and maintain employment. It includes funds for an urban Aboriginal component, capacity building and integrated programming for youth, persons with disabilities and child care (First Nations and Inuit only).

National First Nations Telehealth Project

The national First Nations telehealth project involves five First Nations communities in BC, Alberta, Saskatchewan, Manitoba and Quebec. It envisions telehealth as a community based technology, and involves participation of community members, health care providers and band councils. Nursing stations in each community will be electronically linked to the larger provincial system in order to access services normally provided in larger centres. All five communities will have an audiovisual link, and some may include connections with certain technologies such as electrocardiograms or ear/nose/throat diagnostic equipment to enable specialists to perform tests remotely.

The project has a budget of $2 million, which is directed to both capital and operational expenditures. Infrastructure and training will be completed by July 2000, and the pilot projects are slated to conclude by March 2001. In addition, strategic consultation and education in the post-project time period is being planned at both the political and community (health care delivery) level.

Aboriginal Peoples Survey – First Nations and Inuit Regional Longitudinal Health Survey

Statistics Canada conducted its first national survey on Aboriginal people (the APS) in 1991. Six years after APS, a First Nations and Inuit led process resulted in the FNIRHS. It is a community-based and First Nations/Inuit controlled initiative which involved approximately 15,000 respondents (10,000 adults and 5,000 children) in 185 communities throughout 9 provinces (including Labrador). It was developed in response to a need for comprehensive health information on First Nations and Inuit. Currently, these communities are excluded from national health surveys conducted by Statistics Canada. The FNIRHS has provided valuable information on the health of First Nations and Inuit communities in the areas of children's health, elder health/residential schools, chronic diseases, non-traditional tobacco use, functional disabilities and activity limitations, continuing care, dental health and community wellness.

A joint survey process is being planned in 2001 for APS II and the second longitudinal wave of the FNIRHS, now called the First Nations and Inuit Regional Longitudinal Health Survey (FNIRLHS). Currently, a memorandum of understanding is being drafted between the Assembly of First Nations under the direction of the FNIRLHS National Steering Committee and Statistics Canada. It will address data sharing protocols, access and ownership of First Nations and Inuit information, regional implementation processes, training and capacity development. This process will prove extremely beneficial to the development of a First Nations Statistical Institute which is currently in discussion between the AFN and Statistics Canada via the Fiscal Relations Round Table.

Statistics Canada is consulting with the Métis and Inuit regarding the development of similar joint APS-Métis and APS-Inuit survey components. In addition, the APS-Implementation Committee (comprised of representatives of Aboriginal organizations, federal departments and an ex-officio representative of the provincial/territorial governments) is working with HRDC to develop a children's survey as a component to the APS-FNIRLHS. It is envisioned that the children's survey will serve as a baseline for a longitudinal process or an Aboriginal component to the existing National Longitudinal Survey of Children and Youth.

First Nations Information Governance Committee

In response to the burgeoning initiatives in First Nations health statistics, data and indicators, a need for a national and regional coordination of First Nations health information has been identified. The AFN has recently established a First Nations Information Governance Committee which will take on this coordination task and focus on the development of First Nations capacity at both the regional and national levels to deal with the information requirements associated with many of the health initiatives described above. As First Nations move towards self-government, it will also facilitate the transition of information gathering, statistical and analytical responsibilities from FNIHB and other federal departments to First Nations control. As a start, it is expected that the FNIRLHS and the FNHIS will establish formal linkages with this new governance committee as its mandate is refined and an implementation plan developed.

Canadian Institutes of Health Research

The Canadian Institutes of Health Research (CIHR) have recently been established to serve as the federal government's primary funding agency for health research in Canada. The institutes integrate a broad range of health research activity in Canada, including basic biomedical and applied clinical research, research into health services and health systems, as well as research related to the health of society, culture and populations. The CIHR Institute of Aboriginal Peoples' Health will support research to address the special health needs of Aboriginal people.

PART II: Aboriginal People And HIV/AIDS

Introduction

In the first years of the epidemic in the Aboriginal population, HIV/AIDS affected primarily homosexual/bisexual men (also referred to as two-spirited people in some Aboriginal cultures) as it did in the general Canadian population. The exact number of Aboriginal people who were infected then, and even now, is unknown as ethnicity information is not uniformly collected by all provinces. Available data indicates that prior to 1989, over 80% of Aboriginal AIDS cases were two-spirited men (see next section), and was still well over 60% in the 1989-1993 time period. The following section on HIV/AIDS epidemiology provides an overview of the progress of HIV/AIDS in the Aboriginal community over the past 10 years and the evidence of its movement into the intravenous drug user population.

The majority of the Aboriginal persons living with HIV/AIDS (APHAs) early in the epidemic were found in the urban centres of Vancouver, Toronto and Montreal. Typically, they had lived away from their communities for years and felt that they could not return home due to AIDSphobia and fears of rejection. This isolation from community support was likely a main contributing factor for APHAs' early advocacy and leadership in the AIDS movement. APHAs served as workshop and conference speakers, volunteers, board members, and consultants to AASOs and other Aboriginal organizations. APHAs have also been instrumental in incorporating traditional and cultural approaches to understanding and living with HIV/AIDS.[58]

Aboriginal community-based HIV/AIDS projects began in 1990/91 led by APHAs and sponsored by non-Aboriginal AIDS service organizations or community organizations located in urban locations. In 1994, a coalition of Aboriginal AIDS service organizations (AASOs) and APHAs formed the National Aboriginal APHA Network with the mission of assisting in empowering Aboriginal people infected and affected by HIV/AIDS. The name of the organization was soon changed to the Canadian Aboriginal AIDS Network (CAAN), to reflect the majority representation of AASOs on the governing council. The section on existing approaches to service delivery (page 51) elaborates on the integral role of these organizations in the HIV epidemic.

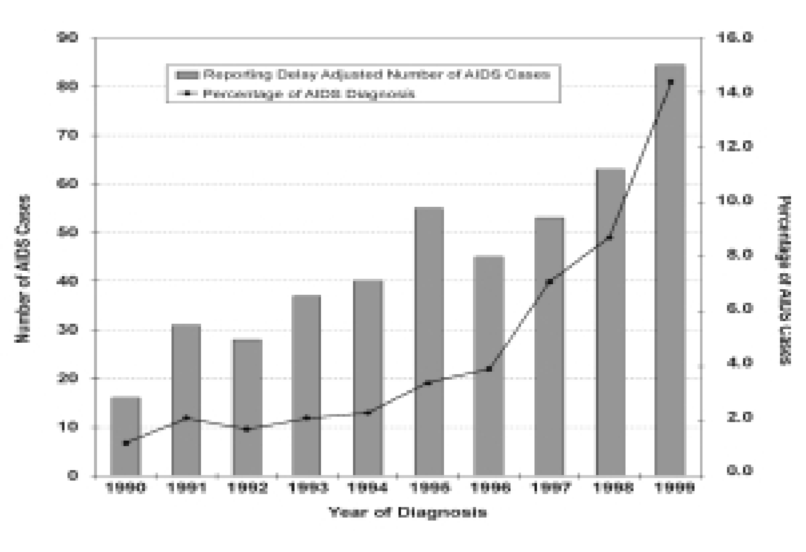
The government's response through the National AIDS Strategies (NAS) I and II and the CSHA has shown an increasing commitment to Aboriginal issues. In NAS I and II, targeted funding was provided to First Nations and Inuit communities. In response to calls for a specific Aboriginal strategy, the CSHA includes Aboriginal programs directed to all Aboriginal groups. The Aboriginal component of the CSHA is detailed more fully on page 33.

The HIV/AIDS Epidemic Among Aboriginal Peoples, Bureau of HIV/AIDS, STD & TB, Health Canada

AIDS Case Reporting

Over the past decade, the AIDS epidemic has risen steadily in the Aboriginal population in Canada and has become a serious concern, particularly among those living in inner-cities. Of the 85% of total AIDS cases with known ethnic status, the proportion of Aboriginal cases rose from 1% before 1990 to 15% in 1999 (see Figure 4). From the beginning of the epidemic to December 31, 1999, out of 16,913 cumulative AIDS cases reported to the **National AIDS Case Reporting and Surveillance System**[59], 371 were indicated as Aboriginal. The majority of these cases are male (78%) and the most common exposure categories are men who have sex with men (52.4%), injection drug use (24.0%), men who have sex with men/injection drug use (13.2%). For Aboriginal women, injection drug use (58.5%) and heterosexual activity (24.4%) are the most commonly identified exposure category.

Figure 4
Annual Number and Percentage of Aboroginal AIDS Case Reports, Canada, 1990-1999



Figures 5 and 6 illustrate the trends in the AIDS epidemic among Aboriginal males and Aboriginal females from the early epidemic (before 1991) to the current epidemic (1997-99). In the male population, there is a shift from men who have sex with men population to injection drug use population. For the female population, the shift is from the heterosexual population to the injection drug use population.

Figure 5
Trend Over Time of Male Aboriginal AIDS Cases by Exposure Category Canada, Data Cumulative to December 1999

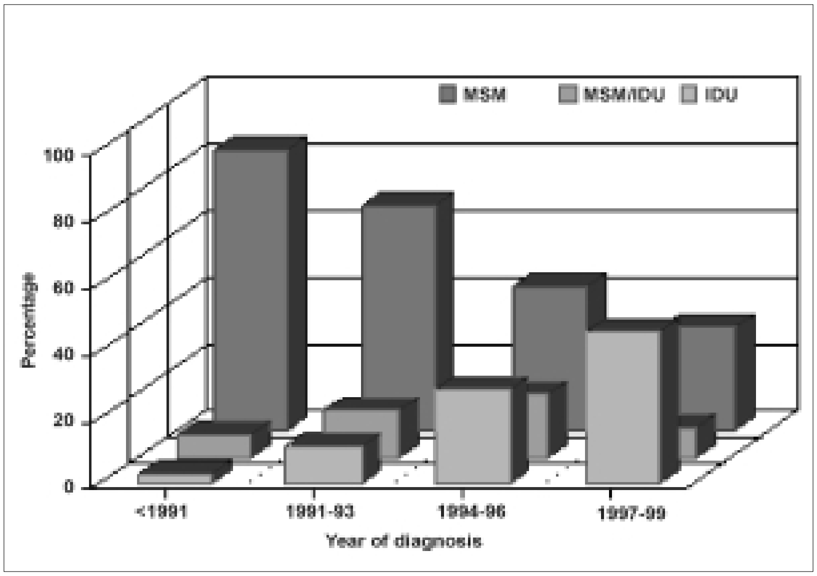
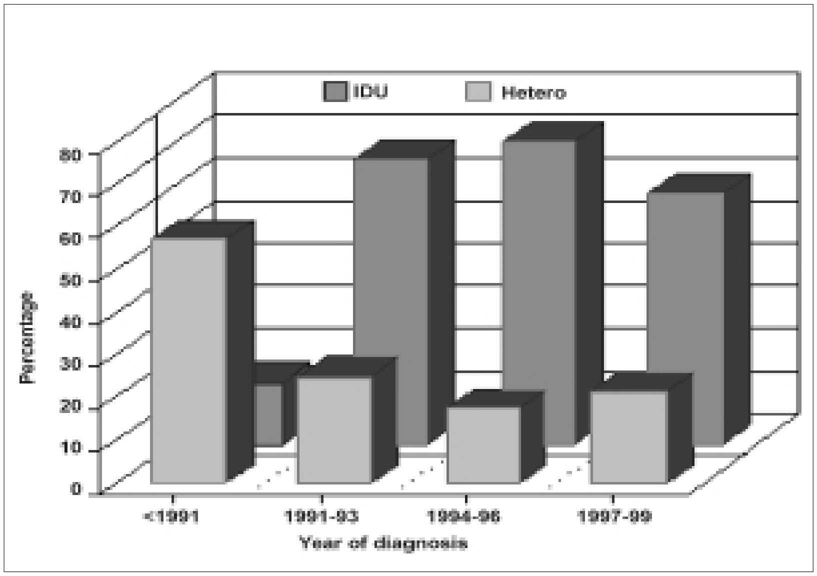


Figure 6
Trend Over Time of Female Aboriginal AIDS Cases Canada, Data Cumulative to December 1999



As of December 1999, compared to non-Aboriginal AIDS cases, Aboriginal AIDS cases are younger (28.6% vs 17.1% for the less than 30 years of age) and more likely to be attributed to injection drug use (24.0% vs 4.2% for men, 58.5% vs 18.1% for women). In addition, the proportion of women among Aboriginal AIDS cases is almost triple that of non-Aboriginal AIDS cases (22.2% vs 7.7%). Data on reported cases of diagnosed HIV infection in Canada shows these same differences between Aboriginal and non Aboriginal cases.

With respect to studies on HIV prevalence done among Aboriginal people or in sub-populations with Aboriginal markers, prevalence rates varied from 0.4%-29.7% in Vancouver (men who have sex with men, Native alcohol and drug treatment centres, inmates, and needle exchange programs-NEPs), 1.8%-2.1% in Alberta (Calgary NEP, STD clinics), 0.4% in Prince Albert (IDUs, sexual partners of IDUs, and inmates), 13.4% in Winnipeg IDUs, 7.7%-7.9% in Ontario (province-wide NEPs, self-report by on-reserve people who had been tested for HIV), and 1.4% in Montreal street youth. Overall, these prevalence rates are similar to those of corresponding non-Aboriginal groups, but the relatively small amount of data cannot rule out the possibility that rates are in fact higher among Aboriginal people. These studies also show that Aboriginal persons are over-represented in some high-risk populations, such as inner-city IDU populations and prison inmates.

Monitoring HIV Infections

The estimated number of prevalent HIV infections among Aboriginal populations was 1,430 in 1996 and increased 91% to 2,740 prevalent HIV infections in 1999. This represents 5.5% of all prevalent HIV infections in Canada in 1999. There were 370 new infections among Aboriginal populations in 1999 (9% of all new HIV infections), 64% of which were attributed to the exposure category IDU, 17% were attributed to heterosexuals, 11% to MSM and 8% to MSM-IDU.

Studies of risk behaviour among Aboriginal injection drug users, clientele of sexually transmitted diseases (STD) clinics, youth, inmates, and men who have sex with men indicate that Aboriginal populations are vulnerable to HIV infection for several reasons. Transmission of HIV within this group is facilitated by high rates of STD's, substance abuse (including injection drug use); and other health and social issues. Unemployment, low incomes, receipt of social assistance, lack of stable housing, low educational attainment, and mobility have been identified as risk factors in recent studies of Aboriginal people with HIV/AIDS. Other HIV/AIDS risk factors associated with socio-economic status include low rates of condom use, increased risk of sexual abuse or non-consensual sex, poor self esteem and inability to demand safe sexual practices or decline sex, increased alcohol and drug use which predisposes to high risk behaviours and over representation of Aboriginal people in settings where there is an increased risk of HIV contact, such as in prison and on the street. In addition, high transient movement of Aboriginal people between inner cities and rural or reserve communities brings the risk of HIV to even the most remote Aboriginal communities.

Monitoring the HIV epidemic among Aboriginal Canadians at this time is still proving to be difficult. Collection of valid data among Aboriginal persons is constrained by many factors. These include incomplete ethnicity information on AIDS and HIV cases, delayed and under-reporting, possible differences in access to confidential HIV testing between Aboriginal and non-Aboriginal populations, and the difficulty associated with generalizing the findings from most studies. Despite these limitations, available evidence suggests that Aboriginal people are infected at a younger age than non-Aboriginal people, that injection drug use is the most important mode of transmission, and that the HIV epidemic among Aboriginal people shows no sign of abating.

Compared to information obtained before 1998, more data is now available on Aboriginal people. This can be explained by numerous factors. For AIDS case reports, ethnicity reporting by provinces and territories has improved over time, from 84.5% in 1990 to 87.8% in 1995 and 93.7% in 1999. Correspondingly, the Aboriginal group witnessed the greatest increase in the proportion of reported AIDS cases, from 1.2% in 1990 to 3.4% in 1995 and 14.4% in 1999. In addition, with a strengthening of Aboriginal specific prevention programming underway, it is likely that the number of reported new infections in this population will increase as more individuals come forward for testing. Furthermore, available data from HIV studies with Aboriginal markers (e.g. inmates, street youth, injection drug users, and STD clientele) help interpret HIV transmission among those living in inner-cities.

The Bureau of HIV/AIDS, STD and TB, Health Canada continues to strengthen the reporting system of HIV, AIDS and STD for all Canadians, including Aboriginal peoples. Officials within BHST are collaborating with the province/territories, FNIHB, Aboriginal communities, the Aboriginal Working Group on HIV/AIDS Epidemiology and Surveillance, and other federal programs on issues related to HIV epidemiology and surveillance among Aboriginal people to improve the understanding of HIV epidemiology in order for Aboriginal communities themselves to more effectively guide prevention and care programs. Appendix 2 provides information on the activities of the BHST in the areas of epidemiology and surveillance related to Aboriginal issues.

The Canadian Strategy on HIV/AIDS (CSHA)

The national approach to addressing HIV/AIDS began in 1990 with Phase I of the National AIDS Strategy (NAS). This strategy supported a variety of research, surveillance and community development activities. In 1993, NAS II continued the momentum of the previous three years, and emphasized the building of partnerships, with other federal departments, provincial and territorial governments, non-governmental organizations, the private sector, professional groups and major stakeholders. Directed funding was provided to First Nations and Inuit communities to develop and implement community-based activities in prevention, awareness, care and support.

In the summer of 1997, a national consultation process was initiated to provide guidance over a continued national strategy on HIV/AIDS. A separate Aboriginal consultation was conducted by CAAN. It found that NAS I and II were judged to be largely ineffective in reaching the Aboriginal population. The consultation report recommended a national Aboriginal HIV/AIDS Strategy which would encourage the formation of provincial and territorial approaches to Aboriginal issues in HIV/AIDS as well as promote networking, linkages and information sharing. The larger national consultation supported this recommendation, however in more general terms, speaking of the need to focus on high risk groups and to improve cross-jurisdictional collaboration.

The CSHA which evolved from the Canadian consultation process is guided by the policy directions of enhanced sustainability and integration, increased focus on those most at risk, and increased public accountability. A specific Aboriginal approach has been defined in the CSHA; this approach involves dedicated funding to develop partnerships with Aboriginal communities to address the unique needs of Aboriginal people living on reserve or in urban settings. It is a broad strategic response across the Strategy with initiatives in the areas of prevention, community development, care, treatment and support, and improved coordination of HIV programming.

Advisory Bodies and Working Groups

A number of national HIV/AIDS advisory bodies or working groups exist whose mandate includes Aboriginal issues:

> **National Aboriginal Reference Group for HIV/AIDS (NARGHA):** This was a short-term Aboriginal advisory body which was established at the start of the CSHA to help inform and guide the consultative process on the development of administrative guidelines for the $1.2 million Non-Reserve First Nations, Inuit & Métis Funding Program funding in PPHB. (The CSHA funding allocations are described in the following section.) The work of NARGHA, which included all national Aboriginal organizations as members, concluded with the release of these guidelines in November, 1999;
>
> **Aboriginal Working Group on HIV/AIDS Epidemiology and Surveillance:** This group provides guidance to the Bureau of HIV/AIDS, STD and TB of on issues of HIV/AIDS epidemiology and surveillance specific to Aboriginal people. It also is involved in data interpretation, proposal review and enhancement of communities' capacity to understand and use epidemiologic information in program and policy development;
>
> **First Nations and Inuit HIV/AIDS Focus Group:** This is an FNIHB advisory body which had a major role in providing direction, including an operational plan, on the allocation of the $2.5 million funds in the previous strategy. The additional $1.1 million in the CSHA is allocated to FNIHB regions on a formula basis. The group is now re-evaluating its objectives and role in HIV/AIDS particularly in view of the presence of other CSHA advisory bodies with Aboriginal representation which have similar objectives;

The Interbranch Committee on HIV/AIDS and Aboriginal People (ICHAAP): ICHAAP plays an internal coordinating and information sharing role among the federal branches which have varying degrees of involvement with Aboriginal issues in the CSHA. It is not an advisory body to the CSHA, rather an external working group;

Ministerial Council on HIV/AIDS: The Council advises the Minister of Health on aspects of HIV/AIDS which have a national scope. The Council currently has two members who represent the Aboriginal population, and has established a Special Working Group on Aboriginal Issues (SWGAI) to report to the Council on issues specific to Aboriginal people and HIV/AIDS;

Federal/Provincial/Territorial Advisory Committee on AIDS (FPT AIDS): FPT AIDS has an essential role in facilitating interdepartmental cooperation on policy issues within federal, provincial and territorial governments, and intergovernmental cooperation among them. Its objectives are to identify emerging issues, propose common strategies, and enhance intersectoral efforts to address HIV/AIDS. It has formed a FPT Working Group on Aboriginal Peoples and HIV/AIDS;

Interim Working Group: At the National Aboriginal HIV/AIDS Planning Summit held in March, 2000 one of the main recommendations flowing from this meeting was the establishment of an Interim Working Group to follow up on the summit, to review planning summit themes and develop an appropriate action plan and draft a working Aboriginal collaborative framework. This framework will be designed to assist all Aboriginal peoples in implementing the goals and objectives of the CSHA through a coordinated flow of information between the analysis and policy areas and the front line prevention and community-based action. The Interim Working Group's time frame is June - December, 2000. The Summit participants recommended that the Interim Working Group's membership include four persons appointed from each of the AFN, MNC and ITC and three persons from Aboriginal HIV/AIDS groups.

Figure 7 provides additional details on the mandates and activities of the six current committees/ working groups.

Figure 7
National Advisory Bodies: HIV/AIDS and Aboriginal People

Advisory Body	Scope	Activities
Inter-branch Committee on HIV/AIDS and Aboriginal People (ICHAAP)	All Aboriginal populations	Share information among Health Canada branches to ensure a coordinated and balanced approach to Aboriginal issues in the CSHA. Terms of reference are being developed and consideration is being given to the inclusion of the development of an action plan which would consider all activities of the department related to HIV/AIDS for Aboriginal people.
First Nations and Inuit HIV/AIDS Focus Group	First Nations and Inuit communities	Facilitated First Nations and Inuit control of HIV/AIDS activities at the community and national level, through the development and subsequent monitoring of a First Nations and Inuit operational plan in NAS II.
Working Group on Aboriginal Peoples and HIV/AIDS (FPT Advisory Committee on AIDS)	All Aboriginal populations	The working group has completed an environmental scan of issues and is determining the collaborative actions that FPT AIDS can take with other partners to address the epidemic among Aboriginal peoples.
Aboriginal Working Group on HIV/AIDS Epidemiology and Surveillance	All Aboriginal populations	Development of a plan to solicit community input into governmental HIV/AIDS programs. Review of proposals submitted to BHST related to Aboriginal issues. In association with CAAN, the development of a manual “Understanding HIV/AIDS Epidemiology: HIV/AIDS Surveillance Among Canada’s Aboriginal People” and workshops on the interpretation and use of this manual. Presentations at national/international meetings on data relevant to Aboriginal communities.
Special Working Group on Aboriginal Issues (Ministerial Council on HIV/AIDS)	All Aboriginal populations	Consult with communities and prioritize issues, inform the Council on issues affecting Aboriginal people and HIV/AIDS and assist the Council in advising the Minister on the Strategy.
Interim Working Group (National HIV/AIDS Planning Summit)	All Aboriginal populations	Review planning summit themes and issues; develop an action plan; draft a working Aboriginal collaborative framework.

LCDC: Laboratory Centre for Disease Control

Figure 8
Aboriginal Components in the CSHA

Name	Source	Amount	Eligible Population	Scope
Non-Reserve First Nations, Inuit & Métis Funding Program*	PPHB	$1.2 million. In 1999: directed funding; after 2000: contribution agreements**	non-reserve Aboriginal organizations	Development of community-based infrastructure of non-profit, voluntary agencies and community groups.
Prevention, Care and Treatment Programs Unit	PPHB	$0.1 million: 50% contribution agreements 50% directed funding	non-reserve Aboriginal organizations	Prevention and community action activities such as health promotion and education related to HIV/AIDS.
Prevention and Community Action Program	PPHB	$0.1 million contribution agreements	health professions working with HIV/AIDS	Educational development and related initiatives for health professions, e.g. social work and nursing.
Policy Integration and Coordination	PPHB	$0.1 million	department funds	Support for the examination of HIV/AIDS issues with respect to Aboriginal people that require policy integration and coordination nationally.
Aboriginal Research Program for Community-Based Research	PPHB	$.3 million	Aboriginal communities	Provides funds to develop research capacity in Aboriginal communities
Aboriginal Research Program, HIV/AIDS Policy, Coordination and Programs Division	PPHB	$0.5 million contribution agreements	Aboriginal communities and academic sector	Provides dedicated funding towards HIV/AIDS research that is relevant to Aboriginal communities. Partnerships between communities and researchers are encouraged
First Nations and Inuit HIV/AIDS Program	FNIHB	$1.1 million: dispersed by regional FNIHB offices	First Nations and Inuit communities	Community-based projects in (1) education, prevention and research; (2) training, development and capacity building; (3) communications and social marketing

* PPHB also provides funds through the AIDS Community Action Program (ACAP). ACAP does not have a specific Aboriginal component, however Aboriginal organizations are eligible. Operational funding and project specific funds are provided to community-based organizations directly involved in front line HIV/AIDS issues.

**directed funding: funding is determined by government. Contribution agreements: organizations apply for funding in a competitive process and receive funds through financial agreements.

IACB: Information, Analysis and Connectivity Branch; PPHB: Population and Public Health Branch; FNIHB: First Nations & Inuit Health Branch

Aboriginal Funding

The CSHA differs from the two previous National AIDS Strategies in having well defined funding opportunities which are targeted to all Aboriginal groups involved in HIV/AIDS work. In NAS II, the only Aboriginal-specific funding allocation was the $2.5 million annually which was provided to First Nations living on reserve and Inuit communities for community-based programming. This amount became part of FNIHB's A base funding at the conclusion of NAS II, and is directly provided to First Nations living on reserve and Inuit communities as part of contribution or integrated agreements, or health transfer arrangements.

In the CSHA, funds specifically identified for Aboriginal populations are administered through three branches of Health Canada: Population and Public Health Branch (PPHB), First Nations & Inuit Health Branch and Information, Analysis and Connectivity Branch (IACB). These funds totalling $3.4 million are also classed as A base in that they are permanent Health Canada programs. Figure 7 provides details on advisory mechanisms related to Aboriginal HIV/AIDS issues. A description of the IACB Aboriginal Research Program, PPHB research projects and two other CSHA programs which are not designated Aboriginal but include Aboriginal populations are provided below.

Aboriginal Research Program

The Aboriginal Research Program, which is delivered through the HIV/AIDS Policy, Coordination and Program Division, PPHB has a budget of $500,000 from the CSHA (Figure 8). It was initially administered without an established advisory group. A national Aboriginal stakeholders consultation for the program occurred in July, 1999. The NHRDP which originally administered the program established an advisory reference group to aid in the implementation of the consultative recommendations. This group was of very short duration due to incompatible views of the members on what organizations should represent the Aboriginal HIV/AIDS research constituency. The lack of resolution of this issue of membership has underscored a gap in the Aboriginal component of the Strategy related to its inability to reconcile of one of the basic tenets of the CSHA – community involvement – with the expectations of the five national Aboriginal organizations that they be the primary representatives of the advisory group.

The NHRDP proceeded with a redesign of the Aboriginal Research Program through the Community-Based Research Program Advisory Reference Group who advise on the parallel non-Aboriginal community research program at NHRDP.[60] This redesign has been described as more friendly to qualitative research and is more inclusive of Aboriginal participation in all facets of the research process.[61] Significant features of the Aboriginal Research Program redesign include:

- A second scoring system has been included in proposal evaluation. This scoring addresses community relevance of the proposals;

- The category of eligible expenditures has been expanded to include remuneration of principal investigators and rent costs;
- The criteria for the assessment of expertise of principal project personnel now include presentations and attendance at conferences in addition to peer review publications;
- The proposal peer review process is chaired by an Aboriginal person. Of the nine members, all but two are Aboriginal and the committee includes representation from both the academic sector and the community.

Capacity development remains an issue with this program. In the September, 1999 intake, five proposals were received, of which two are being considered for funding. In recognition of this, the original $800,000 which was allocated in the CSHA for the Aboriginal Research Program has been reduced to $500,000 with the balance redirected to the Aboriginal Capacity-Building Program for Community-Based Research administered by PPHB.

Population and Public Health Branch

Appendix 3 lists Aboriginal projects currently funded as of March, 2001 through PPHB programs. There has been no one major focus for funded activities, as projects include strategy or action plan development, education and communication activities, and awareness and community development activities.

Correctional Services Canada

Correctional Services Canada (CSC) has a $600,000 allocation from Health Canada under the Strategy, for both the Aboriginal and non-Aboriginal federally incarcerated population. A CSC task force was established in 1994 to investigate the issue of HIV/AIDS and Aboriginal inmates. It developed recommendations relating to the special needs and concerns of incarcerated APHAs, including the development of a comprehensive strategy and access to traditional healing by inmates. As a follow up, in 1998 a working group was established to create an Aboriginal-specific strategy directed to HIV/AIDS, an activity which is currently in progress. One of the major components of this strategy being developed is a peer counselling program to be delivered by Aboriginal peers.[62]

Bureau of HIV/AIDS, STD & TB

At the BHST, CSHA funds for surveillance activities are expended for departmental activities and research initiatives originating from affected communities or researchers that address the gaps in HIV epidemiology information. All groups including those which are Aboriginal can apply to this fund.

Critical Issues

A presentation of issues which are critical to a discussion of HIV/AIDS as it affects the Aboriginal population must be interwoven with a review of general issues in the health system related to provision of services to Aboriginal people. HIV/AIDS, by virtue of the severity of the disease and the need at times for intensive health care, can serve to magnify long-standing issues in service delivery, as well as present challenges which are unique to the disease. Structural and jurisdictional factors result in issues which span the HIV/AIDS prevention through treatment/support continuum. Communities themselves may present barriers to care, through restrictive values or a lack of professional capacity to deal with HIV/AIDS. Policy issues are related to the CSHA funding processes and the lack of representation of Aboriginal people at ministerial level government decision-making tables concerning health care. An elaboration and discussion of these issues is presented below, beginning with those which stem from general concerns in the health system as a whole and moving to those which are specific to HIV/AIDS.

The Role of the Environment

The poor health status of Aboriginal people have been detailed above. Low levels of well-being (physical, mental, emotional and spiritual) combined with delays in accessing testing or treatments due to fear of discrimination or cultural inappropriateness of services can have a variety of ramifications in an individual's response to HIV/AIDS, including hastening the progression of the disease and increasing the intensity of services needed.

Socio-economic status has been identified as a risk factor for HIV/AIDS and Aboriginal people in a number of studies.[63] In a Vancouver study of risk factors for HIV infection among young Aboriginal and non-Aboriginal MSM, Aboriginal MSM were significantly more likely to be unemployed, live in unstable housing, have annual incomes less than $10,000 and receive income assistance. As well Aboriginal men had higher depression scores and were more likely to have been paid for sex.[64] This trend can also seen among Aboriginal HIV positive persons in general. In a British Columbia wide study which surveyed Aboriginal participants in an HIV/AIDS drug treatment program, in comparison to non-Aboriginals, Aboriginal participants were significantly younger, more likely to be female, unemployed, have annual incomes less than $10,000, to have never graduated high school and to have no stable housing.[65]

Aboriginal people are over-represented in the HIV-positive IDU population. In Vancouver's IDU population, those IDUs who were Aboriginal were more likely to be female and HIV positive, and less likely to be enrolled in methadone treatment.[66]

Other studies have found the Aboriginal HIV positive population to be more mobile than other HIV positive groups[67], with the HIV epidemic reaching remote rural communities.[68] As well, marginalized HIV positive populations may find it more difficult to sustain HIV antiretroviral therapy. When the IDU population and non-IDU population was compared in Vancouver, not only were IDUs more likely to be Aboriginal, they are also significantly less likely to use antiretroviral therapy even though these drugs are provided at no cost to PHAs in BC.[69]

Other HIV/AIDS risk factors in Aboriginal communities associated with socio-economic status include low rates of condom use, increased risk of sexual abuse or non-consensual sex, increased rates of sexually transmitted diseases, poor self esteem leading to an inability to demand condom use or decline sex, increased alcohol and drug (non-IDU) use which predisposes to high risk behaviours, and over representation of Aboriginal people in settings where there is an increased risk of HIV contact, such as in prisons and on the street[70,71]. Even though IDU is an established mode of transmission of the virus among Aboriginal people, homosexual sex remains key in the epidemic for many Aboriginal people.

Delivery of Health Services

In 1998, FPT AIDS commissioned an environmental scan on policy issues related to Aboriginal HIV/AIDS issues. Federal, provincial and territorial policy and program officials, and community organizations involved in HIV/AIDS and Aboriginal issues participated. The top ranked issues which were reported to affect both Aboriginal people with HIV/AIDS and Aboriginal communities coping with AIDS, were access to programs and availability of resources (broadly defined as including financial, human and information resources). Other highly prioritized issues included the need for culturally appropriate services and for information on program structures or approaches which are successful in addressing HIV/AIDS in this population.[72] A definition of culturally appropriate was not provided to the survey respondents, however, it was broadly interpreted by respondents as encompassing the range from access to Aboriginal care givers to utilization of traditional processes in prevention, care and support.

Health services to Aboriginal people are highly influenced by structural limitations and jurisdictional issues. These are both described below in general terms and are followed by a discussion on their impact on provision of services to APHAs and Aboriginal communities.

Structural Barriers

Geography, isolation, and small community size are structural barriers to health care in Aboriginal communities outside of urban areas. In terms of remoteness, over one-third of First Nations communities are classed as semi-isolated, isolated or remote by Health Canada. Semi-isolated communities (14.4% of all communities) have road access, however are situated more than 90 kilometres away from physician services. Isolated communities (19%) must rely on scheduled air flights for physician services. A further 3% of communities are classed as remote and do not have scheduled flights, road access, and possess minimal telephone or radio services.

Accessibility to services and comprehensiveness of services are, not surprisingly, major issues in Aboriginal health. Communities with geographic challenges have small populations and minimal on-site health services. Resident health and health-related staff might include two nurses, a community health representative (CHR), and environmental health officer, a National Native Alcohol and Drug Addictions Program (NNADAP) worker, a social worker and a worker funded through the federal Brighter Futures-Building Healthy Communities programs. Health professionals such as general practitioners, dentists, dental assistants and optometrists provide services on a visiting basis, and persons requiring specialized or emergency medical treatment must travel to larger centres.

Jurisdictional Barriers

Layered on top of general structural issues of community location and size, are those relating to jurisdiction. Jurisdiction over the provision of health services to Aboriginal people is a long standing issue between the federal and provincial governments and has created two types of jurisdictional problems: (1) those stemming from the provincial governments' position that the federal government has responsibility for certain health services to those Aboriginal persons classed as Indians under the *Indian Act*; and (2) those which have arisen between different groups of Aboriginal people created by the *Indian Act*, individuals having status under the *Act* and individuals without status.

1. First Nations and Inuit Health Services

Through the *BNA Act*, provinces are responsible for establishing and delivering health services. It is generally recognized that the federal government is responsible for providing services to First Nations and Inuit communities, except for hospital and physician services which are provided by provincial and territorial governments under the *Canada Health Act, 1984* to all insured persons including First Nations and Inuit. For non-isolated communities, physician services are generally provided in health clinics located in the community or in a neighbouring community, and First Nations access hospital services in neighbouring towns and cities. However, for remote or isolated First Nations or Inuit communities where delivery of physician services is more challenging, provinces in the past have typically reimbursed the federal government which provides primary care services, often contracting with university medical faculties for physician services. With the continuing development of capacity among First Nations and Inuit communities for delivery of health services, this intermediary role of the federal government is becoming less necessary and some First Nations may now have direct agreements with provincial governments for these services.

It is the federal government's position that Health Canada's program activities in First Nations and Inuit communities (and the NIHB Program which is provided to on and off reserve First Nations and Inuit) are assumed as a matter of policy and do not trigger a legal responsibility to provide those programs. The federal position is based on the special relationship that exists between the Crown and First Nations and Inuit and has been enunciated in the 1979 *Indian Health Policy*. [73]

The current mandate of FNIHB with respect to First Nations and Inuit is to ensure the availability of, or access to, health services for status Indians and Inuit; to assist First Nations and Inuit communities in addressing health inequalities and disease threats; and to attain a level of health comparable to that of other Canadians living in similar locations. The Branch provides for the delivery of community based programming in First Nations and Inuit communities (outside of the territories) and the provision of the NIHB Program to all status Indians and Inuit. As mentioned above, it also provides primary care services on reserve in remote and isolated communities.

Health services not contained in the *Canada Health Act*, such as allied health services situated outside of hospitals, mental health, community-based prevention and home care may or may not be provided by provincial governments to First Nations and Inuit. This is of increasing significance as downsizing and restructuring of health services in the provincial systems create situations of cost-shifting. Provincial reforms involving delisting of previously insured services, early discharge from hospital and increased need for home care, user fees for prescriptions and/or removal of First Nations and Inuit clients from pharmacy plans have placed increasing pressure on federal resources provided through the NIHB Program and community-based programs. Federal health funds for First Nations and Inuit are capped, therefore there is a limited capacity to absorb new health needs, even in a population of demonstrated poor health.

The need to deal with different jurisdictions can also complicate service delivery even in cases where both provincial and federal resources are provided directly to the community. For example, the Labrador Inuit Health Commission receives federal program funding, however general health services are run by the provincial government of Newfoundland. At an administrative level, problems of coordinating reporting mechanisms between different agencies have been reported, as having difficulties in the sharing of information and acceptance of referrals.[74] Some provinces, as will be discussed below, have instituted provincial strategies in HIV/AIDS which involve Aboriginal people, federal and provincial governments, and which have valuable coordination, collaboration and information sharing functions.

2. Health Services to Other Aboriginal Groups

Métis and non-status Indians are in a jurisdictional void, not by virtue of being identified in a piece of legislation, but rather through their exclusion. Métis people have reported to a Parliamentary Standing Committee on Health that they are often excluded from provincial efforts to set up service delivery mechanisms as the provinces do not want to acknowledge a fiduciary relationship to Métis peoples as one of the Aboriginal peoples. As well, Métis may be treated differently from First Nations by the federal government, even if they live in neighbouring communities. First Nations communities may allow Métis to access their federally funded health services, but this group is not eligible for the federal NIHB Program that provides resources to cover costs of medical transportation to urban hospitals and specialists.[75]

> Jurisdictional divisions can be effective barriers to care for Aboriginal people who are new to an urban setting and do not understand the intricacies of the health system. These persons may be shunted from one jurisdiction to another when seeking services. As put to the Standing Committee on Health, for urban health agencies attempting to meet the needs of Aboriginal people, the deciding factor for eligibility for many health services not covered under the *Canada Health Act* is the governments' designation of "who's Indian, who's not Indian, who's Métis, who's status and who's Inuit."[76]

For HIV/AIDS, issues in service provision, whether it be HIV prevention, testing or providing services to APHAs, arise from the structural and jurisdictional factors presented above. A discussion of relevant issues is provided below and have been obtained from a environmental scan on issues in HIV/AIDS and Aboriginal people.[77]

Gaps in services provided – In Aboriginal communities both rural and urban, the mandates of social and health agencies may be unclear due to jurisdictional issues. With respect to First Nations, some provincial services may be restricted to the off-reserve population only, whereas federal services through FNIHB are targeted to on-reserve. Only First Nations and Inuit with status are eligible for pharmacy, dental, vision and transportation benefits provided through the federal NIHB Program. Other Aboriginal groups, the Métis and non-status First Nations, have recourse to provincial benefit plans, but the scope of these are not comparable to NIHBs and Aboriginal people must demonstrate financial need to access the provincial plans. As well, Aboriginal people may not be knowledgeable about the extent of these provincial plans in covering HIV/AIDS related needs. Compounding this uncertainty may be gaps in services caused by poor coordination among jurisdictions.

Lack of continuity of care – For First Nations and Inuit, there may be poor coordination between provincial and FNIHB mandates, from a policy level down to the individual client. Communication issues may exist between urban physicians and the community health professionals who are responsible for providing care between physician visits. Few Aboriginal case managers exist who can make the necessary links between services in different jurisdictions.

Access to programs and services – Small, geographically isolated communities do not have access to the many specialized services that APHAs require, particularly when requiring treatments for medical conditions, as few specialized services for HIV/AIDS are provided directly in the communities and there is little commitment from provincial or regional health authorities to do so. Provinces may not provide outreach to communities for Aboriginal people or post-testing services for APHAs. Problems of access are suggested by the fact that APHAs are diagnosed at a later stage of infection, are seeking care later in the course of this illness and utilize the health system less.[78] The appropriateness of the system in providing health services is discussed more fully in the following section discussing traditional healing approaches.

Few AASOs and funding issues – Jurisdictional issues make it difficult for AASOs to successfully obtain funding from governments which may have restrictions on target populations and types of programs funded. The AASOs which exist have been described as inadequately resourced to meet demand. As will be elaborated below, the scope of services funded in AASOs is related to funding source, not need of clients, which is inconsistent with a holistic approach to care.

Lack of coordination – Jurisdictional issues may prevent First Nations groups from participating in provincial HIV/AIDS strategies developed for Aboriginal people. This reluctance is related to concerns that participation in provincial initiatives will cause an off-loading of federal fiduciary responsibilities. Coordination issues also exist among federal government departments which are involved in providing health and health-related services to Aboriginal people: Health Canada, DIAND, CSC and HRDC.

Traditional Healing Approaches

Jurisdictional and structural barriers aside, access to services can also be impeded by cultural differences in the type of health programs offered or the way they are delivered. Aboriginal people have advocated for the provision of health services by Aboriginal professionals, in the community if possible, using educational materials and processes which are sensitive to language and culture. Community-based care can provide a cultural grounding and engender self-reliance and mutual responsibility which in turn can validate and enhance the healing process.[79] This has ramifications past the treatment of APHAs. The restoration of community well being is attributed to community empowerment which occurs when health and social service delivery are under Aboriginal control and services are delivered by Aboriginal professionals.[80]

Although the importance of addressing broad determinants of health has been recognized in the Canadian health system for many years, it is still primarily focussed on a medical, illness care, model. As a result, care to APHAs, which is obtained from this western system, may not be grounded in cultural traditions, and health care is generally provided by non-Aboriginal persons. In contrast, the Aboriginal concept of well-being is founded on a holistic approach to healing, which in some cultures may be called the Medicine Wheel or Circle of Life. This concept acknowledges the many forces which combine to affect an individual's physical, mental, emotional and spiritual domains. This approach has been embraced by the Aboriginal Healing Foundation which requires holistic processes to be used in successfully funded projects, and permits traditional or western approaches to healing. Traditional healers are envisioned as self-regulating in this system and guidelines on their practice and conduct have been developed. One of the objectives of the newly established OAAPH concerns the affirmation of Aboriginal traditional healing practices through validating holistic traditional practices and medicines.

A Medicine Wheel and Healing Circle approach has been used successfully by AASOs as a foundation for integrating AIDS related information into a more appropriate cultural context, particularly for Aboriginal street youth who are HIV positive. The education methods developed for mainstream, middle-class, well educated youth have had little if any success in reaching these Aboriginal youth. This population is in a constant daily battle to survive, and HIV may be less of a priority than other daily basics of living. The fundamentals of the Medicine Wheel in describing the life process have been adapted as a model for teaching about HIV and its progression, as well as a way of explaining why prevention and education must be aimed at the entire person, in addition to their medical symptoms.[81]

Many Aboriginal people see a complementarity of traditional medicine practices to western care. APHAs have spoken positively about the benefits of the sweat lodge, Medicine Wheel and Healing Circle, both in the care and treatment of seropositive individuals, and in general HIV/AIDS education and prevention activities.[82] However, traditional medicine is not universally accepted, and many Aboriginal communities are unwilling to accept all forms of traditional healing practices in their health system.

Traditional medicine operates outside of government regulations, as it is inherent to Aboriginal culture. In most cases, there are little or no direct linkages between the traditional system and the western-based system, except in some hospitals which allow traditional healers to treat Aboriginal patients upon request and in the programs of some addiction treatment facilities. The government does not pay for traditional healing services, however, transportation costs of traditional healers visiting Aboriginal persons are reimbursed from the NIHB Program.

CSHA Funding

The components of the CSHA which provide funding for organizations and groups providing services to Aboriginal people or conducting research on Aboriginal issues has been detailed previously. In addition, Aboriginal organizations are eligible to apply for funding from the mainstream CSHA community funding program: the AIDS Community Action Program (ACAP) of PPHB and from the Aboriginal Research Program of NHRDP.

The processes used by CSHA funding bodies have raised a number of concerns among Aboriginal organizations and researchers as they are seen as creating barriers to the access of resources. The application process for the Aboriginal Research Program at the NHRDP was presented in May, 1998 at a meeting of the LCDC Aboriginal Working Group on HIV/AIDS Epidemiology and Surveillance. Twenty-six Aboriginal participants at this forum expressed grave concern over the rushed nature which accompanied the design of this program in the CSHA and the fact that Aboriginal people were not directly involved in its development, implementation or management. Furthermore, the design was not seen as promoting capacity building, and the deadline for proposal submissions to the first intake of applications was judged to be too short.[83] The RFPs had already been issued from NHRDP before these concerns were raised. As a reaction to these concerns, a moratorium was subsequently imposed in the program until an appropriate consultation occurred.[84] A number of changes were incorporated into the RFP process through a program redesign (see page 38) and were incorporated in NHRDP's September, 1999 RFP.

In PPHB, $1.2 million of the $1.5 million in designated Aboriginal funding is directed to the Non-Reserve First Nations, Inuit and Métis Funding Program which is exclusive to Aboriginal communities and organizations. In response to the CSHA commitment to building capacity in Aboriginal communities, Prevention and Community Action Programs Unit of then HPPB undertook an extensive national consultation, beginning in late 1998, with Aboriginal AIDS workers, health services workers and political representatives, to advise Health Canada on the development of administrative guidelines for this fund. In addition to the consultation process, NARGHA was struck to provide additional advice in the formulation of the guidelines. In November of 1999 the *Guidelines for Non-reserve Urban and Rural First Nations, Inuit and Metis AIDS Project Funding* were finalised and released to the community during the call for proposals for funding commencing in April 01, 2000. At the conclusion of the solicitation and peer review process, twenty projects were funded for a total of $1.2 million over each of the next two fiscal years.

General concerns from the Aboriginal community which have been expressed about the Aboriginal funding programs include:[85]

- Project funding may have restrictions based on a jurisdiction's responsibility for delivering services. For example, federal funding cannot be provided for activities which include direct service delivery, and must be directed to projects such as developing a resource manual for counselling, not the activity of counselling itself. In addition, PPHB project funding is not intended for on-reserve activities, which is the responsibility of FNIHB. AASOs provide services in a holistic fashion, and funding definitions are seen as artificial and counterproductive in the context of providing services to persons in need;

- When applying for research support, Aboriginal organizations must compete directly with submissions from academic organizations in the NHRDP process. This was felt to be an inequitable process. NHRDP has responded to this concern by integrating the recommendations solicited by the national consultation to maximize applicant equity, such as allowing principal investigator remuneration and rent as eligible expenditures.

- Peer review committees which evaluate funding proposals may not be sufficiently culturally sensitive. Funding priorities may be based on the interests of mainstream ASOs, not on the concerns and priorities of AASOs. The new RFP process which has been designed by NHRDP now includes an Aboriginal peer review process.

Advocacy and Representation

Aboriginal organizations working in HIV/AIDS and in health generally desire greater participation in decision-making when relevant government policy is developed or other issues of importance to Aboriginal people are discussed by governments. Aboriginal people are often included in consultation processes, but not in the actual formulation of policy. Some progress in this area has been seen federally with the development of partnerships and accords between the federal government and national Aboriginal organizations as a result of *Gathering Strength*.[86]

In their path to self-determination, Aboriginal people are requesting full participation in decisions which affect their communities. The *First Nations Health Policy* developed by the AFN states that the federal government should partner with First Nations in the review of all laws, regulations and policies which affect First Nations health, and that full consultation, consent and agreement of First Nations be obtained on any changes to health care delivery systems.[87] Although this may be regarded as an extreme position of First Nations, partnership is firmly in the federal government-Aboriginal agenda. For example, partnership is one of five strategic priorities of FNIHB[88], and is one of four areas of concern expressed by the AFN to the federal Minister of Health.[89] Partnerships from Health Canada's perspective relate to new cooperative working relationships, which could encompass shared decision making, increased participation in policy development and joint work planning.

Partnership achievements of *Gathering Strength* in its first year include an Accord which has been negotiated with the CAP. This Accord has established mutual priorities, such as the need to develop government structures and institutions to address Aboriginal interests off reserves. A Métis National Council Action Plan has been developed to provide a framework for the MNC and its affiliates to conduct follow-up *Gathering Strength* consultations. Similarly, an Inuit Action Plan is being developed with the ITC.[90]

This new partnership relationship with the federal government has not extended to Aboriginal representation on federal/provincial/territorial committees. Mechanisms have not been defined or developed to facilitate a participation of Aboriginal authorities in the larger FPT context. However, Aboriginal people are represented on some working groups or sub committees which report to FPT committees, such the Aboriginal Perspectives sub working group of the National Children's Agenda (a FPT Ministerial Council on Social Policy Renewal initiative).

In some provinces, partnerships have been created between provincial and federal governments and Aboriginal organizations as part of collaborative strategies to address HIV/AIDS among Aboriginal peoples, and deal with jurisdictional issues. These initiatives are described more fully in the following section on existing approaches.

Health Governance

A strong message from the FPT AIDS environmental scan conducted by its Aboriginal working group was that approaches and strategies within the CSHA directed to Aboriginal people should be developed and owned by Aboriginal people. Within this model of Aboriginal governance, other relevant components also seen as integral included:

- partnerships to address jurisdictional issues and coordinate with provincial strategies;

- capacity building and community development;
- a holistic approach, where HIV/AIDS is integrated into a larger health and social context; and
- a focus on special groups such as youth, mentally ill, addicted persons, Elders, women, and gay/bisexual persons.[91]

As Métis, First Nations and Inuit move toward more autonomous health governance models as a strategy to cope with urgent health problems, new partnerships will be necessary to facilitate this evolution. AASOs have historically taken the lead advocacy role with the federal government in issues such as AIDSphobia and homophobia. With the changing face of AIDS from a primarily gay disease to include Aboriginal women, children and IDU populations, AASOs will require flexible approaches which are inclusive of a broad spectrum of HIV clientele, and at the same time, which build partnerships and linkages with evolving health governance structures within Aboriginal communities. A complementarity of roles of the national Aboriginal HIV/AIDS organization (CAAN) and national Aboriginal political organizations which are representing health governance authorities is evolving, and policy development and advocacy responsibilities are being clarified.

NARGHA served to facilitate the formation of informal partnerships within its membership of national Aboriginal political organizations, APHAs, AASOs and national Aboriginal organizations working in the area of HIV/AIDS, and Health Canada. This group helped to make connections between AASOs which have largely operated autonomously at the local and regional level, and national organizations which can advocate on their behalf. One of the issues which has resulted from these networking processes is the need to develop capacity at a national level, so that national Aboriginal organizations are fully apprised of HIV/AIDS issues and can effectively support and advise Aboriginal health governance bodies. This acquisition of knowledge can hopefully facilitate local leadership into more openly talking about sexuality in a healthy way. Repression about sexuality issues has many causes, and some attribute it at least partly to the legacy of sexual and physical abuse suffered by Aboriginal people in residential schools, as well as to value judgements about alternative sexual lifestyles.

Aboriginal health governance bodies must address the challenges of integrating HIV/AIDS into a community health system already overstressed coping with a growing elderly population and increasing rates of diabetes, cardiovascular diseases and other chronic diseases. For First Nations, the demands on the NIHB Program continue to rise, and in the fixed health resource envelope, these increasing NIHB costs directly take resources away from other community health services. Some First Nations are concerned about negotiating increased control through Health Transfer arrangements (described more fully in Appendix 1) which specifies an envelope of fixed resources which may be inadequate to address emerging needs in HIV, diabetes and other chronic illnesses.

Homophobia has been recognized as an issue in some Aboriginal communities, and the resulting moral judgements and negative attitudes can make implementing awareness and education strategies challenging. Denial and intolerance restrict openness in discussing the topic of HIV/AIDS, and may prevent persons at risk from being tested for the virus. As well, negative community attitudes can result in APHAs leaving their communities and their own personal support networks in a very vulnerable period of their lives where the support of family and friends would be a valuable part of their treatment process.

Denial by Aboriginal leaders that HIV/AIDS is an issue in their communities and their discouragement of specific programming has been reported in previous consultations on HIV/AIDS, and has been attributed to concerns that community health and social resources will be depleted by the needs of APHAs. This attitude may be manifested in band councils' opposition to community-based harm reduction strategies such as needle exchange programs, and in unwelcoming attitudes of communities to intravenous drug users. APHAs may be unable to access services if they are restricted to only those practising abstinence from alcohol and drugs. It should also be said that many communities, despite these issues, are implementing innovative methods of education and prevention, sometimes with the explicit support of the band council, even to the extent of passing a band council resolution welcoming an APHA back into their community.

Existing Approaches to Service Delivery for HIV/AIDS

There are three main modes of delivering HIV/AIDS programs and services to Aboriginal people: through the provincial and territorial health systems, AASOs/ASOs, and community-based programs.

Provinces and Territories[92]

As stated above, all Aboriginal people are eligible for provincial or territorial hospital and medical services, irrespective of place of residence or status under the *Indian Act*. At the beginning of the HIV/AIDS epidemic in Canada, Aboriginal people were not recognized as a high risk group, particularly as the disease appeared first in homosexuals and persons with hemophilia. With some exceptions, provinces historically do not have a practice of providing targeted health programming to Aboriginal people, as this group is expected to use provincial medical and hospital services on the same basis as other citizens. As the disease continued to unfold, there was a growing perception that Aboriginal people were at a higher risk for HIV infection than other Canadian populations, and has resulted in some provinces establishing programs and initiatives targeted at this emerging problem among Aboriginal people. Given the diversity of provinces and territories in Canada and the many Aboriginal nations which exist within its borders, it is not surprising that a variety of approaches are now seen. Provinces are increasingly working to establish Aboriginal components in provincial HIV/AIDS strategies, or at least to consult with First Nations, Inuit and Métis groups and APHAs in the development of these strategies.

The *Northwest Territories* and *Yukon* have universal HIV/AIDS strategies which have centrally included Aboriginal issues, by virtue of the high proportion of Aboriginal people in their general populations.[93] The provinces have varying levels of involvement with respect to consultations with Aboriginal people in their jurisdictions regarding HIV/AIDS programs and services.

Ontario: Ontario was the first province, in 1993, to initiate the development of an Aboriginal HIV/AIDS Strategy.[94] Holism and a community-based approach are integral components of this strategy. Strategy staff work with APHAs to connect them with AIDS service organizations (ASOs) and the one AASO in Toronto, and also provide counselling and outreach services. Even though the strategy was developed with participation of off-reserve Aboriginal groups only[95], the provincial government provides HIV/AIDS funding to First Nations communities and has done so since 1989.

Alberta: Alberta was the first to develop an *interjurisdictional* Aboriginal HIV/AIDS Strategy which combines provincial and federal cooperation. In this initiative, both levels of government provided funds for a community-focussed HIV prevention project. A community development worker provided support to communities in accessing HIV/AIDS prevention funding resources, and in conjunction with Aboriginal communities, developed the Tree of Creation to set the strategy-building process on a nature-based, culturally appropriate course. Use of the tree recognizes and celebrates the connection to the land that the Aboriginal people hold.

British Columbia: An interjurisdictional Aboriginal HIV/AIDS Task Force, now named the Red Road HIV/AIDS Network Society, has been established and has released a strategic plan. It was formed from a previous FNIHB focus group which decided to expand its membership to address some of the jurisdictional barriers and gaps in HIV/AIDS services to Aboriginal people.

Quebec: In 1998, a provincial coalition was created to develop an First Nations and Inuit HIV/AIDS Strategy. This body includes provincial, federal, First Nations and Inuit representation. In February, 2000, the strategy was released (*Le Cercle de l'Espoir*) and a permanent committee formed which has the responsibility for implementing the strategy.

Saskatchewan: Aboriginal issues are included in existing provincial government advisory bodies on HIV/AIDS which include Aboriginal and FNIHB representation.

Manitoba: Efforts to collaborate on a common HIV/AIDS strategy through an interjurisdictional group were suspended. Even so, the provincial strategy has committed the province to addressing HIV/AIDS issues affecting Aboriginal people in a complementary effort which includes Aboriginal direction and control, government consultation and which is integrated with provincial and national strategies.

Prince Edward Island, Nova Scotia and New Brunswick: Aboriginal people were consulted during PEI's HIV/AIDS strategy development. In Nova Scotia and New Brunswick, consultations are currently underway on provincial HIV/AIDS strategies. In both these cases, the Atlantic First Nations AIDS Task Force represents First Nations interests in these activities.

Newfoundland: There are no HIV/AIDS programs which are specifically intended for Aboriginal people. Government programs individually determine their own priorities.

Aboriginal AIDS Service Organizations and NGOs

Initially, Aboriginal community based HIV/AIDS projects were administered under non-Aboriginal ASOs or community organizations which operated in urban locations. Now approximately eight AASOs exist on a provincial level (also two organizations are located in the Yukon which serve Aboriginal and non-Aboriginal clientele), which are of varying sizes and reflect the different cultural experiences and beliefs of their clients, governance, staff and volunteers. These organizations meet the needs of Aboriginal people through a variety of mechanisms. A sampling of activities among this group includes:

- networking and the development of cooperative relationships with other organizations, including ASOs;
- development of training programs, awareness manuals and other materials
- participation in research initiatives;
- policy development;
- hosting of conferences and retreats; and
- outreach and education services, hospital and home visits, buddy support programs.[96]

AASOs receive much of their operational funding through ACAP, although some provincial funding does occur, for example in the 2 Spirited People of the 1st Nations in Toronto, and in the Atlantic region, First Nations band councils have directed FNIHB HIV/AIDS funding to the Atlantic First Nations AIDS Task Force. As well, FNIHB may provide project-specific funding such as interjurisdictional collaborative strategy development in provinces.

Although AASOs were developed primarily in response to urban Aboriginal needs, and funding rules based on jurisdiction limit the flexibility of these organizations in extending their services to First Nations living on reserve, these organizations are status-blind and provide services across jurisdictions to First Nations, Metis and Inuit individuals and communities.[97] The Atlantic First Nations AIDS Task Force is a unique model of on and off reserve collaboration in the four Atlantic provinces (except Labrador). The organization is supported through the FNIHB funding that the Atlantic First Nations bands receive annually, and provides programs for First Nations regardless of residence. The FNIHB funding is initially allocated to bands for community-based initiatives (on-reserve), and the Atlantic region bands unanimously have chosen to direct these funds to support one AASO rather than conduct separate community-specific initiatives. Chiefs of these bands renew their support for the Task Force annually with band council resolutions. Some supplemental project funding is received from PPHB. Provincial governments in the Atlantic region do not provide funding to the Task Force.

AASOs and APHAs are represented at the national level by CAAN. This organization has provided a national advocacy and networking role which is guided by the following objectives:

- to provide national forums for APHAs to express their needs and concerns;
- to ensure access to services for Aboriginal people infected and affected by HIV/AIDS;
- to provide relevant, accurate and updated HIV/AIDS information to Aboriginal people.

The CAAN work plan for 2000/01 is centered on organizational renewal, as CAAN positions itself in more of a policy coordination and collaboration capacity than its previous focus on advocacy, support and leadership. The work plan also includes more effective communication and partnership mechanisms. To this end, the organization is establishing partnerships with the Canadian HIV/AIDS Legal Network (see below) and the Canadian AIDS Treatment Information Exchange. Partnerships are also being developed with national Aboriginal organizations, such as AFN and MNC. Another area for CAAN will be the development of an international information sharing and policy development network. CAAN is currently working on the development of a national Aboriginal HIV/AIDS strategy with support from Health Canada.

NGOs involved in the mainstream HIV/AIDS movement have also made contributions in the area of Aboriginal people and HIV/AIDS. The Canadian AIDS Society (CAS) represents over 100 community-based organizations across the country (of which five are AASOs) which provide services to Aboriginal as well as non-Aboriginal clients. In 1994, the CAS member groups supported a resolution to support AASOs in the development of an Aboriginal-specific national strategy on HIV/AIDS. In 1996, CAAN conducted a study with the CAS to develop a strategic plan which would address interjurisdictional barriers and facilitate participation of APHA in planning and implementing Aboriginal-specific responses to HIV/AIDS.[98] Based on a CAS resolution in 1998, CAS works with CAAN and other Aboriginal people to include their issues in CAS activities whenever possible, such as in the National AIDS Awareness Campaign, and the Aboriginal stream in the 1st and 2nd Canadian HIV/AIDS Skills Building Symposia.

The Canadian HIV/AIDS Legal Network and CAAN are formalizing a partnership agreement to continue work on legal issues relating to HIV/AIDS and the Aboriginal population. The Network previously released three discussion papers based on discussions with key informants working in the field of Aboriginal people and HIV/AIDS. These documents concerned the topics of discrimination; jurisdiction and funding; and HIV confidentiality and testing. This relationship with CAAN is in alignment with recommendations adopted by the Legal Network board which address the development of partnerships with Aboriginal organizations and Aboriginal people working in the field of HIV/AIDS and the support of these organizations and individuals by contributions of resources and expertise when appropriate and possible.[99]

Community-Based Activities

Along with provincial/territorial services and AASOs, community-based activities form the third approach for delivery of HIV/AIDS programs and services to Aboriginal people. Although the distinction may be moot, in this paper community-based activities refer to those initiatives which are occurring outside of AASOs. (It is recognized, however, that AASOs in themselves, are a form of community-based HIV/AIDS response.) With that distinction in mind, the majority of Aboriginal community-based HIV/AIDS prevention activities occur through the $3.6 million per year which is provided to First Nations and Inuit communities from FNIHB ($1.1 million from CSHA, $2.5 million in the A base FNIHB funding). Three areas of activity have been identified as priorities for First Nations and Inuit HIV/AIDS funding: (1) education, prevention and research; (2) training, development and capacity building; (3) communications and social marketing.[100]

National Fora on HIV/AIDS and Aboriginal People

Recommendations and Conclusions

A review has been provided in this section of national level policy processes which have addressed the area of HIV/AIDS and Aboriginal people. This review has shown that a call to action regarding the HIV epidemic and Aboriginal people has been made by various groups over the past 10 years, on issues relating to jurisdiction and the need for collaboration among governments, culturally appropriate services, barriers to diagnosis and testing, access to services and the need for community-based programming. Aboriginal issues tend to get little exposure when discussed at the same time as other numerous issues involving HIV/AIDS in the Canadian population. This lack of emphasis concerning a population which has for the past nine years continued to have increasing representation in AIDS diagnoses (from 2% in 1989 to 15% in 1999[101] among a people which comprise only 3% of the total Canadian population), lends support to the call for a National Aboriginal action plan within the CSHA.

Joint National Committee (JNC) on Aboriginal AIDS Education and Prevention

The first national committee with a mandate to investigate HIV/AIDS issues among the Aboriginal population was the Joint National Committee (JNC) on Aboriginal AIDS Education and Prevention which was established in 1989. At that time, concerns were being raised that a unique response to HIV/AIDS would be needed in the Aboriginal community and secondly, that Aboriginal communities might experience a different pattern of transmission, one which was primarily heterosexually based. Nineteen recommendations were developed by the JNC, one of which was the first call for development of a specific Aboriginal AIDS education and prevention strategy. The recommendations emphasized a community-based approach for prevention and education which included development of Aboriginal human resources, and linkages with existing AIDS community groups. Research was another area of importance with five recommendations elaborating on knowledge and behaviour studies, traditional healing, economic impact of HIV/AIDS, and the implications of HIV/AIDS on health transfer (a financing mechanism of Health Canada which transfers administrative control of some FNIHB programs to communities).

Departmental Aboriginal AIDS Committee, Health Canada

The Departmental Aboriginal AIDS Committee (DAAC) was established in 1992 with the mandate of ensuring a coordinated and balanced approach to Aboriginal HIV/AIDS issues under the National AIDS Strategy. In 1995, DAAC undertook a review of the fifteen major federally funded reports which addressed Aboriginal HIV/AIDS issues from 1990 though 1995. This review examined key policy and strategic planning recommendations with a view to identifying common themes, issues and future directions. The following themes emerged from this review process:

- Socio-economic issues relating to high risk behaviours, safe environments, cultural differences and discrimination;
- Disease transmission issuesincluding issues of diagnosis, barriers to testing, STDs, tuberculosis and treatment;
- Program development issues involving jurisdiction, access, transfer, education, and HIV/AIDS issues affecting Aboriginal inmates.[102]

Parliamentary Standing Committee on Health

When placed among the many issues in the NAS II which were discussed in the Parliamentary Standing Committee on Health's 1995 review, Aboriginal concerns did not receive much attention. Information was received from one witness, the Director General of Indian and Northern Health Services of Health Canada who spoke of the risks of the spread of the disease among Aboriginal people in urban, rural and remote settings. The Standing Committee dealt with this issue in two general recommendations; one that current awareness and prevention programs be evaluated for their effectiveness in reaching target groups, and second recommending that the balance of funding between broad campaign approach and specific programs be addressed in the National AIDS Strategy.[103]

Indigenous People's Gathering - Satellite Conference at the XIth International Conference on AIDS, Vancouver, BC, July 7 & 10, 1996

Resolutions at the Indigenous People's Gathering noted the need for a greater emphasis on the issues of indigenous peoples of the developed world, including prevention, treatment, advocacy and support services. As well, the lack of indigenous specific research on the correlation of alcohol abuse and the transmission of HIV was highlighted, with a resolution to increase research into the issues involved in the rapid progression of HIV to AIDS and the long-term survival of HIV positive indigenous people.[104]

Report of the Aboriginal Consultation of the National AIDS Strategy Phase I and II, 1997

Neither of the two National AIDS Strategies which preceded the CSHA had explicit components directed to all Aboriginal people. In 1997, CAAN conducted a consultation which looked at the effect of the National AIDS Strategies I and II on the Aboriginal population. It found that 78% of the Aboriginal people consulted viewed the NASs to have been unsuccessful in reaching the Aboriginal population. Even though awareness of HIV transmission was increased, this was not translated into behavioural changes. The report noted that community-based initiatives were encouraged in the strategies, however more needed to be done to ensure that culturally appropriate materials and expertise were available to support communities in their efforts.

The consultation's conclusions included a call for a national Aboriginal HIV/AIDS strategy, increased funding for AASOs, resolution of interjurisdictional barriers and continued research involving local cooperation and collaboration.

National AIDS Strategy, Phase III Consultation: A Summary Report of Results, 1997

In the fall of 1997, a consultation process was held to obtain input, suggestions and advice on the directions and priorities for Phase III of the National AIDS Strategy (which was subsequently renamed the CSHA). This report documented the recommendation by CAAN that a national Aboriginal strategy be developed and that the needs of Aboriginal people should be incorporated broadly throughout a new Canadian strategy.[105]

This consultation process did not look at Aboriginal issues separately, and for the most part Aboriginal references were in the context of other high risk or target groups such as women, youth and street people. Issues specific to Aboriginal people which were in included in the report were related to jurisdiction and the need for collaboration across jurisdictions, not just provincial-federal interactions, but also among different federal department providing services to Aboriginal people. As well, the report highlighted a submission which called for dedicated funding to support an Aboriginal strategy (beyond the $2.5 million per year allocated to FNIHB under Phase II for First Nations and Inuit), and additional funding for national and Aboriginal AIDS service organizations.

BHST Annual Aboriginal HIV/AIDS Epidemiology and Surveillance Meetings

The BHST hosts an annual meeting of Aboriginal stakeholders which provides a forum to voice concerns, share new HIV information, and facilitate informed decisions about the collection of HIV/AIDS epidemiology and surveillance information. These meetings, which began in 1996, have involved from 60 to 75 representatives from national/regional/local Aboriginal organizations, provincial governments, academic institutions, Health Canada and CSC.

At the first meeting, an Aboriginal working group was created to develop an action plan for epidemiology and surveillance areas. The action plan which was created consists of five elements: renegotiation of the working group's mandate; development of clear guiding principles; improvement of the working group's decision-making capacity; consideration for the development of an ethics panel or review committee for Aboriginal proposals; and orientation of new participants in their role in the area of surveillance and epidemiology. The second meeting resulted in the review of and recommendations for more standard terminology for the collection of Aboriginal markers such as First Nations, Inuit and Métis.

At the 1998 meeting, the Aboriginal caucus of the working group developed three major recommendations: a stronger and extended mandate of the working group; communications to the Minister of Health regarding the need for direct and meaningful Aboriginal participation; and the termination of the RFP process in the NHRDP's Aboriginal Research Program until an appropriate consultation with Aboriginal representatives could be completed. In 1999, a plan was finalized which addresses community consultation into government HIV/AIDS programs.

National Aboriginal HIV/AIDS Planning Summit

On March 23 - 25, 2000, a National Aboriginal HIV/AIDS Planning Summit was held in Winnipeg, Manitoba that gathered Aboriginal partners and stakeholders in the CSHA. The planning summit reviewed what has been achieved to date in combination with a general review of the current framework, mechanisms and panels that address Aboriginal concerns under the CSHA. The purpose of the review was to identify new evolving collaborative frameworks and mechanisms which would ensure an easy flow of pertinent/relevant information between the steps of Aboriginal HIV/AIDS analysis and policy and the front line prevention work and community-based action.

Participants outlined three action items resulting from the planning summit with respect to a new collaborative framework that will improve the flow of information to assist Aboriginal communities in responding to HIV/AIDS:

1. Identify different funding pockets and when/where organizations can apply.
2. Develop a process for an Interim Working Group to follow-up on the National Aboriginal HIV/AIDS Planning Summit with the express purpose of creating a collaborative framework, mechanism(s) and working plans.
3. Interim Working Group to follow up on the planning summit, to review themes and issues and develop an appropriate action plan and draft a working Aboriginal collaborative framework designed to assist all Aboriginal peoples in implementing the goals and objectives of the CSHA.

Appendix 1

Delivery of Health Services to First Nations and Inuit Communities

The first western medical services provided to Aboriginal communities were directed to public health crises, such as the control of tuberculosis and vaccinations for smallpox. The view that these services were provided mainly to protect neighbouring non-Aboriginal communities is widely held in the literature. The RCMP and missionaries were the first providers of these services along with the Hudson's Bay Company which feared for the health of the Aboriginal hunters and trappers who were its primary suppliers.

In financial terms, services to Aboriginal communities were highly inequitable when compared to the Canadian population. For example, in 1930, the per capita expenditure to Indians was $9.60 compared to $31.00 for non-Aboriginal people.[106]

The Office of the General Medical Superintendent in the Department of Indian Affairs was established in 1904 in response to pressure by reporters and politicians over the deplorable state of Aboriginal health. With this action, the government began its policy of providing health services only to First Nations (Indian) reserves and later to Inuit communities, a policy which has existed to this day, albeit in a more contemporary form which acknowledges the desire for communities to assume control over these services. Other Aboriginal populations have been expected to access provincial services on the same basis as other Canadian citizens.

Between 1905 and 1927, federal government hospitals were constructed and communities were visited by travelling field nurses. These services were often not warmly welcomed by the First Nations communities. First Nations persons may have had to travel lengthy distances to access treatment, health services were totally alien to Aboriginal culture and traditions, health providers were non-Aboriginal and perhaps most importantly, First Nations had no control over their health services and procedures.[107] This began a climate of distrust and misunderstanding between providers and communities which existed well into the latter 20th century.

Inadequate funding for health services remained a chronic problem throughout the era of infrastructure development. Nursing stations and health centres were built in communities and a system of nurses and community health representatives emerged, supplemented by intermittent visits by physicians, dentists and opthamologists. By the 1950s, the Department of Health and Welfare was operating a network of 33 nursing stations, 65 health centres and 18 regional hospitals for registered Indians and Inuit.

Today in isolated and remote communities where there no year around access exists, a nursing station typically provides basic diagnostic equipment and a few beds, with primary care services such as urgent care, short term inpatient care and community health. Patients requiring more intensive care must be transported out by air to provincial health facilities. In First Nations and Inuit communities[108], the nursing and Community Health Representative (CHR) staff are joined by environmental health officers, family and child care workers, social workers, alcohol and drug workers, and persons employed under the federal programs directed to early childhood interventions, such as Brighter Futures, Building Healthy Communities and the Canada Prenatal Nutrition Program.

Up until 20 years ago, nursing and other community health services to First Nations communities were directly provided by FNIHB of Health Canada. Since, then First Nations have been assuming a progressively greater role in the planning and delivery of these services. In the 1979 *Indian Health Policy*, the federal government committed to a greater participation of First Nations and Inuit in this area. This was given additional support in the *Report of the Advisory Commission on Indian and Inuit Health Consultation* (1980) which was written by Justice Thomas Berger. In the RCAP report in 1996 which reviewed this era, the commissioners suggest that even though the report's language was conservative, the ideas contained within it were radical, as it supported the concept of community control by Aboriginal people, and Justice Berger foresaw a complete end to the existing dependency of First Nations and Inuit on the Canadian state.[109]

The period of the 1980s saw the development of administrative capacity among First Nations and Inuit, initially with selected health programs such as National Native Alcohol and Drug Program (NNADAP) and the CHR program. A more comprehensive transfer of administrative authority was initiated in the pilot Community Health Demonstration Program (CHDP) in 1982. Communities participating in this pilot project assumed administration of a portion of FNIHB programming.

In 1987, the demonstration phase of CHDP was over, and the modern period of health transfer began. Health transfer is a financial arrangement between FNIHB and bands or tribal councils which provides communities with greater control over health services. By 1999 approximately 40% of First Nations and Inuit communities have undergone health transfer or are in the developmental process.[110] First Nations cite the gains in flexibility in the use of program funds, more freedom to adapt services to local needs and priorities, reduced reporting paperwork and increased community sense of ownership of health services.

Health transfer has also been criticized on a number of fronts. Some First Nations state that self-determination in health should be part of comprehensive self-government, and that the federal government is pursuing a "dump and run" strategy in health transfer which firstly, divests itself of its responsibility for health, and secondly, that resources provided in transfer are inadequate to address the health needs of First Nations in an effective manner. First Nations are also concerned about the exclusion of off-reserve community members from services and the exclusion of the NIHB Program from transfer (a program which consumes over half of the total FNIHB budget).

Appendix 2

Bureau of HIV/AIDS, STD & TB: Activities Related to Aboriginal Issues

The Bureau of HIV/AIDS, STD and TB conducts national surveillance as well as research on the epidemiology and laboratory science related to HIV/AIDS, sexually transmitted diseases (STD), and tuberculosis. Over the past several years of the national AIDS Strategies, the Bureau has improved Health Canada' s understanding of trends in HIV transmission among Aboriginal persons by maintaining these activities:

- The Division of HIV/AIDS Epidemiology and Surveillance regularly synthesizes and disseminates information on HIV prevalence, incidence, and risk behaviour among all Canadians (including Aboriginal people) to the public and governmental, non-governmental organizations. This work is done through hosting national HIV epidemiology meetings, proactive collection and synthesis of new HIV epidemiology information, production and distribution of the HIV/AIDS Epi Update, the Inventory of HIV Incidence/Prevalence Studies in Canada, HIV/AIDS Surveillance Report and other publications.

  Before April 1999, AIDS data by ethnic status could be obtained from the Division only by request. Beginning April 1999, such information has officially become part of the HIV/AIDS Surveillance Reports where information on Aboriginal AIDS cases can be directly retrieved. This effort resulted from the Division' s multiple negotiations and consultations with provinces, territories, and community groups to obtain such data. The Division has been working with provinces and territories to develop a national HIV database since 1995, to integrate HIV/AIDS surveillance activities into an electronic databases since 1997, and to work toward integrating HIV, AIDS and STD into one surveillance system since 1999. All of these activities aim at providing timely critical HIV/AIDS information to the public and an Aboriginal marker is one of the priority information to be targeted by the Division.

  The Division also supports targeted studies that address gaps in HIV epidemiology information and researchers have been encouraged to obtain Aboriginal markers in their studies. From March 1992 to May 2000, a number of such studies have been funded by the Division, namely studies among inmates, injection drug users and their sexual partners, STD clientele, pregnant women, and men who have sex with men. Results from some of these studies have been used by Aboriginal communities and public health officials in prevention programs directed at injection drug users (e.g. The Four Doorways Project in Winnipeg, Cluster investigation of HIV infection in Prince Albert Health District).

In terms of inter-departmental collaboration, a specific plan was developed in collaboration with the FNIHB HIV/AIDS Program, the Hepatitis C Division, the Division of Bloodborne Pathogens, and the Data Development and Exchange Division to produce a report to better understand the epidemiology of STD, HIV, and Bloodborne pathogens among Aboriginal people in Canada. Working with the Aboriginal community, the collaborative team will assist in the interpretation of report findings and facilitate the use of information in prevention and care programs for these infectious diseases. The long-term aims of the plan are to increase capacity of FNIHB regional offices to collect data, improve research and surveillance among Aboriginal communities, and facilitate the identification of gaps in knowledge and services.

- The Division of HIV/AIDS Modelling and Projection was formed in 2000, as part of a departmental reorganization. The Division conducts trend analyses, modelling and projection for HIV/AIDS, STD, TB and retro-viral infections in Canada, and conducts analyses of the economic impact of these diseases in Canada.
- The Division of STD Control and Prevention provides supplementary information on risk behaviours and its determinants as STD rates serve as a surrogate marker of sex without protection and frequent partner exchange. Since 1998, the Division has set up a national, multi-centre cross-sectional surveillance system in street youth to monitor rates of STDs, HIV prevalence, and risk determinants in this population and Aboriginal markers are to be obtained. So far, Aboriginal youth account for 29% of the subjects entered into the database.
- Since 1996, the Bureau has supported a series of annual meetings for Aboriginal stakeholders and the Aboriginal Working Group to find ways for better collection of HIV information among Aboriginal peoples. Between annual meetings, the Aboriginal Working Group provides guidance and advice related to HIV/AIDS epidemiology and surveillance issues. The working group also helps the Bureau in interpreting and disseminating data relevant to Aboriginal people at national and international conferences, meetings, skills building workshops.

Aboriginal Working Group on HIV/AIDS Epidemiology and Surveillance, PPHB

The working group was created in 1996. The purpose is to provide guidance and advice to BHST on the priorities for collection of HIV epidemiology and surveillance information among Aboriginal people, and to suggest ways to obtain this information in a culturally appropriate manner. The Working Group developed a plan to solicit community input into programming. This plan was presented to the wide audience of community and academic persons at the Canadian Conference on HIV/AIDS Research in May 1999. Part of this plan has also been used by the Canadian Aboriginal AIDS Network to develop a manual “Understanding HIV/AIDS Epidemiology: HIV/AIDS Surveillance among Canada’s Aboriginal Peoples” which was presented at the Canadian Conference on HIV/AIDS Research in April 2000 and the 13th International AIDS Conference

(July 2000, Durban, South Africa). This manual released in June 2000, aims to enhance Aboriginal community capacity in using HIV/AIDS statistics in health and policy planning. The Aboriginal Working Group is also planning a series of workshops to help Aboriginal communities to understand and use the manual mentioned above.

In February 2001, the Aboriginal Working Group of the Division of HIV/AIDS Epidemiology and Surveillance hosted a focus group meeting to discuss how estimates of HIV infections among the Aboriginal community are calculated and to develop a useable report on these estimates. The report will be released at the 2nd Aboriginal HIV/AIDS Summit in May 2001.

Appendix 3

Current Aboriginal HIV/AIDS Projects Currently Underway Population and Public Health Branch

Project Activity Title	Description	Outcomes	Key Results
HIV and Sexual Assault Brochure for Inuit women - translation	The HIV and sexual assault brochure for Inuit women will be translated into several Inuit languages. *Links: Family Violence, FNIHB*	A HIV and sexual assault brochure targeted at Inuit women survivors in Inuit dialects.	Increased awareness of the links between HIV and sexual assault among Inuit women and the community and health professionals working with this population.
Evaluation Capacity Building	This activity will introduce the Aboriginal specific Evaluation model developed in the previous fiscal year to organizations receiving funding under the $1.2 PCAP allocation. In addition to training around evaluation, groups will also be provided an opportunity to present on their project to their peers and discuss the role evaluation will play in their work.	Evaluation workbook that reflects the Aboriginal cultures and beliefs.	Enhanced capacity for community-based groups to undertake evaluations and improve project planning. Enhanced peer accountability.
LINK-UP: An Integrated Information Systems Infrastructure	This project will develop an national information system with an infrastructure for the communication and of dissemination of HIV/AIDS information, including links with all Aboriginal AIDS service organizations, Aboriginal health organizations, population-specific political organizations, and other national non-Aboriginal AIDS organizations.	Dissemination of HIV Prevention information, AIDS resources, and best-practise models to Aboriginal AIDS organizations.	Increased access to information and resources for community-based AIDS organizations.
Labrador Aboriginal HIV/AIDS Project	Building on the results of the Labrador Friendship Centre's HIV/AIDS Surveillance Study, completed recently with the support of NHRDP, the project will develop and implement an HIV/AIDS strategy that reflects local needs and concerns in a culturally appropriate manner.	A strategy to address HIV/AIDS in Labrador communities.	Enhanced capacity by the communities of Labrador to address HIV/AIDS in a collaborative and strategic manner.
Aboriginal AIDS Information Distribution System	Funding is provided to the National Association of Friendship Centre (NAFC) to create an AIDS Page on their web site to link with other web pages and resources.	Dissemination of HIV prevention information and AIDS resources to Aboriginal people and organizations.	Increased access to information and resources for members of the Native Friendship Centre Movement.
Two-Spirit Circle of Friends	This project will address HIV prevention among two-spirit Aboriginals through support and training programs. The project will also enhance the ability of Aboriginal organizations and communities to better address the needs of gays, lesbians, bisexuals, and Two-Spirit individuals and offer cross-culture awareness training on homophobia for non-Aboriginal organizations.	Establishment of a two-spirit support group and training materials around HIV prevention and homophobia.	Enhanced capacity of organizations to integrate approaches to address the specific needs of two-spirit people.

Project Activity Title	Description	Outcomes	Key Results
Healing Our Nations: Community Outreach Project	This project will develop and delivery HIV prevention education outreach programs to the First Nations urban and rural non-reserve communities of Atlantic Canada. The agency will also provide HIV prevention education in the context of cross-cultural training sessions with non-Aboriginal agencies that serve Aboriginal people.	HIV prevention and cross-cultural training materials.	Enhanced capacity of Aboriginal communities in Atlantic Canada to address HIV/AIDS and for non-Aboriginal organizations to assist Aboriginal people.
Four Doorways Project: Phase II	This project will provide training and on-going support for organizations with peer educators who can then integrate HIV prevention with the other health information they deliver to their peers in the street-involved youth and injection drug using communities of Winnipeg. an evaluation framework and contributed to a service manual for HIV positive injection drug users.	Programs to train outreach workers on the integration of HIV prevention messages. An evaluation framework that will be tested and integrated.	Integration of HIV prevention activities in the work of organizations currently providing outreach services to street-involved and IDU populations.
Northern Aboriginal Links for AIDS	This project will develop and disseminate culturally appropriate HIV/AIDS prevention education resources throughout Thompson and region, including the recruitment and training of volunteers for peer outreach, targeting the at-risk groups of youth, women and possibly injection drug users. A strong component of cultural teaching will encourage learning about personal health and safety in the context of HIV prevention.	Culturally-specific teaching materials on HIV/AIDS and cultural learning.	Trained peer educators and an enhanced awareness of HIV prevention in northern Manitoba. Stronger intersectoral response to HIV/AIDS.
Red Prairie AIDS Project	The goal of the project is to deliver HIV prevention education to Aboriginal people in South Western Manitoba, focussing on young people aged 15 to 30, through culturally-based HIV prevention programs to partner organizations; development of an advisory committee to oversee the project; and sustainable partnership agreements with agencies providing services to Aboriginal people.	Culturally-specific HIV prevention program and teaching tools.	Enhanced capacity for communities and agencies in northern Manitoba to address HIV/AIDS and a stronger intersectoral response to HIV/AIDS.
Urban Aboriginal HIV/AIDS Support Service	The Native Friendship Centre of Montreal will provide an HIV prevention education program and promote networking activities with other AIDS service organizations and surrounding Aboriginal organizations/ communities.	Workshops, training materials, and quarterly newsletter.	Increased capacity to respond to HIV/AIDS and stronger collaboration in, and integration of, HIV/AIDS work.
HIV/AIDS Training Project	This project will provide culturally appropriate HIV prevention education training and support to Ontario member Friendship Centres so that HIV prevention becomes an incorporated component of all Friendship Centre programs/services in Ontario.	Models of best practise to integrate HIV/AIDS work into Friendship Centre programs and services.	Enhanced capacity to address HIV/AIDS in an integrated and sustainable manner.
Mino Tibadjumowin “Spreading a Good Message”	The project will first design a culturally specific HIV/AIDS “Training for Trainers” Program targeting First Nations, Inuit and Metis women, youth, and Elders, then implement a one-year HIV/AIDS education outreach strategy in the national capital region.	Training the trainers program and teams of volunteer First Nations, Inuit and Metis women, youth and Elder educators.	Enhanced capacity to deliver HIV prevention messages and increased HIV prevention knowledge among Aboriginal communities in the national capital region.

Project Activity Title	Description	Outcomes	Key Results
"Me and HIV"	Funds for this project will assist with the organization and facilitation of an HIV prevention conference directed at the high-risk Aboriginal youth populations of northern Alberta.	Conference Report	Enhanced awareness of HIV prevention for Aboriginal youth of northern Alberta.
Wiya Wapaki *(For Tomorrow)*	The project will develop and test models to build the capacity of Friendship Centres and Friendship Centre Youth Centres in Alberta to effectively respond to the HIV/AIDS program needs of urban Aboriginal people through training and education on HIV issues.	Best practise models to integrate HIV in the Alberta Friendship Centre movement.	Enhanced capacity to address urban Aboriginal HIV/AIDS issues with stronger community and regional networks to foster information sharing and partnerships.
HIV/AIDS Training and Resources for Addictions and Community Workers	This project will assess the HIV prevention education and resource needs of addiction counsellors and those involved in health promotion in the Aboriginal community. The project includes the development of training and resource materials that reflect the identified needs of this group.	Training manual specific to addressing HIV/AIDS in the context of addictions recovery.	Enhanced integration of HIV prevention work in the area of Aboriginal addictions counselling.
Iqaluit Community HIV/AIDS Fair	This project will develop and facilitate the Iqaluit Community HIV/AIDS Fair, an HIV prevention and education initiative modelled on the idea of a community science fair for youth. Other communities will then be identified to take on the project in the second year.	Model for delivering HIV prevention information to youth in northern communities.	Enhanced awareness of HIV prevention among youth in the north.
Aboriginal HIV/AIDS Education Standardization Project	This project will enhance the coordination and collaboration efforts currently being carried out by the member organizations of the B.C. Red Road HIV/AIDS Network through the standardization of the HIV/AIDS education information being presented to Aboriginal communities in British Columbia.	Production of a culturally appropriate policy and position paper on the standards of HIV/AIDS education for Aboriginal communities throughout British Columbia.	More consistent, culturally appropriate messages about HIV prevention among Aboriginal communities in British Columbia.
Aboriginal HIV/AIDS Prevention Curriculum and Manual Project	This project will further develop existing education tools at Healing Our Spirit to include approaches that are specific to the range of different Aboriginal cultures among the communities of British Columbia.	Curricula and manuals that incorporate HIV information in a manner specific to the various Aboriginal cultures of BC.	Enhanced awareness of HIV/AIDS among the different Aboriginal communities of BC.
Peer Outreach in the Prison Population of Yellowknife, NWT	This project will develop peer educators to deliver HIV prevention education workshops among prisoners in the Yellowknife Correctional Centre. *Links: CSC, GNWT*	Training materials and educational information for prisoners of the north.	Enhanced awareness and knowledge of HIV among prisoners.
Canadian HIV/AIDS Inuit Network	This project will build on efforts to establish a core of HIV educators among Canada's Inuit. Culturally appropriate secondary educational sessions and materials will be developed to expand the knowledge base among educators in the north. *LINKS: FNIHB*	Training materials that are culturally appropriate to Inuit.	Enhanced capacity of Inuit to deliver HIV prevention education in the north.

Project Activity Title	Description	Outcomes	Key Results
Operational Funding for NGO's	Through the operational funding the Canadian Aboriginal AIDS Network(CAAN), the organization has made a commitment to : provide a national forum for its members to express their concerns regarding Aboriginal people and HIV/AIDS; ensure access to services for Aboriginal people living with and affected by HIV/AIDS, and provide relevant, accurate, and up-to-date HIV/AIDS information to Aboriginal peoples.	Contact database; Quarterly newsletter; Discussion papers related to HIV/AIDS prevention, care, treatment and support issues; Increased CAAN membership base.	Greater coordination of the Canadian response to HIV/AIDS related issues and Aboriginal peoples; Enhanced skills of program/service providers in this area; HIV prevention initiatives within Aboriginal communities.
Inter-branch Committee on HIV/AIDS and Aboriginal People (ICHAAP)	An information sharing mechanism meant to insure coordination of efforts and initiatives.	Meeting Minutes	Coordination of CSHA initiatives regarding HIV/AIDS and Aboriginal People.
LCDC Aboriginal Working Group on HIV/AIDS Epidemiology and Surveillance	To provide guidance and advice to LCDC on the priorities for collection of HIV epidemiology and surveillance information among Aboriginal people, and to suggest ways to obtain this information in a culturally appropriate manner. *Links: LCDC, FNIHB*	Meeting minutes	Improved Aboriginal Epidemiology and Surveillance Data and Information.

PPHB Project Listing as of August, 1999 (prepared for the first edition of Situational Analysis: HIV/AIDS and Aboriginal People, August, 1999)

Project Activity Title	Description	Outcomes	Key Results
Peer Education In HIV for Two Aboriginal Target Groups	This project will work toward the reduction in the spread of HIV through a peer program targeted at Aboriginal men in the correctional system and Aboriginal youth in two small Aboriginal communities: Dettah and Ndhilo.	Dissemination of HIV prevention information to Aboriginal people in high risk target populations.	Increased HIV awareness within two high risk target populations. Ongoing support networks within the target populations.
Calgary Urban Aboriginal Outreach Project	Through the formation of new partnerships, this project will provide care, support and education to urban Aboriginal people, especially those at high risk for HIV infection and to deal with traditional issues between on, off and non-reserve.	Dissemination of HIV prevention information to Aboriginal people. Improved levels of service delivery among a host of partners.	Increased access to health and social services in a more structured and seamless manner. Enhanced levels of care and support between on and off reserve services.
The Link Between Addictions and AIDS - HIV/AIDS and IV Drug Use Awareness for Youth	This is the second phase of an existing project which produced a video on IV drug use and HIV/AIDS, targeted at Aboriginal youth at risk of contracting HIV through shared needle use. This project will offer the video content in other formats and in other languages, common to the region.	Multilingual Web Site Multilingual Comic Books	Improved HIV prevention awareness among Aboriginal youth in terms of risk associated with shared needle use.
Action on HIV Prevention, Care and Support	This project will develop a Metis Advisory Group that will develop an action plan framework and facilitate community consultations and focus groups to discuss action plan priorities and the roles of potential partners within the action plan.	Action Plan framework from which to build and Alberta Metis HIV/AIDS strategy.	Collective understanding of what actions need to occur to improve HIV prevention care, treatment and support in the Metis settlement and non settlement communities of Alberta.
An Evaluation of the Ontario Aboriginal AIDS Strategy	A reference group will be established for the design, development and implementation of a joint evaluation process that encompasses all areas of the Ontario AIDS Strategy.	Recommendations to inform the development of a Phase Two Ontario Aboriginal AIDS Strategy.	Development of a Phase Two aboriginal AIDS Strategy that reflects the evolving nature of the HIV epidemic among Ontario's Aboriginal population.
A Needs Assessment of the Two-Spirited Male Population (Jointly funded with FNIHB)	This project is a community-based knowledge, attitude and behaviour study among four-hundred two-spirited men drawn from four urban centres in Canada (Vancouver, Toronto, Montreal and Winnipeg) with an focus on youth.	Collection and dissemination of data to assist in the design of better education and HIV/AIDS prevention for Two-spirited men.	Data will help form more appropriate and effective HIV/AIDS education and prevention programs for two-spirited men by Aboriginal AIDS Organizations in Canada.
Providing Aboriginal Links (PAL)	The project will plan, organize, facilitate and evaluate a "Gathering" of people who are connected to the HIV/AIDS issue in Alberta, Saskatchewan, British Columbia, Manitoba, and the NWT. This activity will also nurture the development of a western Canada network of Aboriginal groups and individuals (WeCan Network).	Gathering to be held in Calgary in April of 1999.	Improved networking and communication among Aboriginal Groups and Individual in Western Canada.

Project Activity Title	Description	Outcomes	Key Results
Coordinating an Inuit response to HIV/AIDS	Inuit Tapirisat Canada (ITC) proposes to develop a communication strategy for its member groups to share basic HIV/AIDS information with Inuit and to raise the HIV/AIDS awareness of the member groups. This communication plan will also involve a survey seeking input on the kind of role ITC should play regarding HIV/AIDS and Inuit.	Communications plan Awareness campaign ITC HIV/AIDS Strategic Plan	Greater readiness by Inuit communities to address HIV/AIDS issues.
Support for the development and implementation of the Quebec Aboriginal AIDS Strategy	This project will be sponsored by the Quebec First Nations Health Commission (authors of the Quebec Aboriginal HIV/AIDS Strategy) and will provide support for a provincial conference to inform Quebec's First Nations, Inuit, and Metis populations about the Quebec Aboriginal Strategy and establish a standing strategy advisory committee. This project is jointly funded with regional FNIHB and Quebec Health.	Conference; Establishment of strategy advisory committee including terms of reference, etc.	Better model of coordination between PPHB, FNIHB, and Aboriginal Stakeholders in the delivery of HIV/AIDS programming in Quebec.
Developing evaluation and strategic planning skills for Aboriginal organizations involved with HIV/AIDS	A contractor will be hired to help develop a training/resource template to assist community-based Aboriginal organizations in the development of HIV/AIDS project proposals. This will include the promotion of this template to key Aboriginal groups/stakeholders.	Resource guide for evaluation and strategic planning.	Stronger, better articulated proposals from community-based aboriginal organizations applying for HIV/AIDS funding.
Aboriginal HIV/AIDS Symposium, AIDS Impact 1999 (Jointly funded with FNIHB)	The Canadian Aboriginal AIDS Network (CAAN) proposes to coordinate an indigenous peoples stream at AIDS Impact 1999. This programme will include a plenary that addresses the comparison of indigenous peoples HIV programs in Canada, Australia, Mexico and the U.S.	Programme Plan for the Indigenous Peoples Stream at AIDS Impact 1999 List of Plenary members, facilitators, etc. Symposium promotion	Greater awareness of various issues related to HIV/AIDS prevention, care and support for indigenous peoples.
Developing an AIDS Action Plan for Metis Women	This Project is sponsored by the Metis National Council of Women and proposes to build on their previous AIDS Awareness project to create a standing HIV/AIDS Committee within their organization that will develop and AIDS Action Plan for Metis Women.	AIDS Action Plan for Metis Women; A national workshop to train women to be HIV Leaders for Metis communities throughout Canada.	Increased awareness of HIV issues for Metis Women and metis communities across Canada.
Building Capacity for Aboriginal HIV/AIDS Community-based Research: A pilot Project	This project will identify community-based Aboriginal organizations working with HIV/AIDS issues affecting urban and other off-reserve Aboriginal peoples in British Columbia's lower mainland and create a project steering committee. This committee will then research initiatives to link with and provide a mentorship to community-based Aboriginal groups regarding how to undertake research projects, and how the results of this research can be translated into meaningful HIV intervention programming; determined and document the operational needs of the organization.	Creation of a project steering committee. Template for Aboriginal Community-based Organizations to undertake community-based HIV/AIDS research.	More effective HIV interventions. Increased Capacity of BC region Aboriginal AIDS Organizations to engage in community -based research.

Project Activity Title	Description	Outcomes	Key Results
Four Doorways Project - Peer leaders for Street involved Youth and Injection Drug Users	This pilot project will develop a model for peer leadership for Aboriginal street-involved youth and injection drug users. The project intends to main peer educators who will provide HIV prevention and other health information to their peers in the above areas and then establish mechanism to provide ongoing support for these peer educators.	Program model and evaluation report.	Creation of partnerships. Increased capacity of MAATF to address HIV/AIDS issues facing IDUs and youth. Model is shared nationally and internationally.
Metis Talking Circles on HIV/AIDS Phase II	This project builds on the successes and limitations of a previous phase and will constitute the cornerstone of a national Metis HIV/AIDS youth strategy that will allow programming to be developed to the community level.	Program model and evaluation report.	Partnership development. Enhanced skills for circle participants. Creation of healthy and supportive environments for those infected/affected by HIV/AIDS.
Identification of HIV/AIDS Programs, Services, and Partnerships within the Friendship Centre Movement	This project will focus on the available HIV/AIDS specific programs across Canada and develop an environmental scan of the existing partnerships these programs may have within their communities, with AIDS service organizations, health services, social services, etc.	Recommendations for the National Association of Friendship Centres.	Opportunities to strengthen existing links and for the development of new links and for the development of new links based on best-models as identified by the scan.
Development of Administration Guidelines for non-reserve Aboriginal HIV/AIDS funding	This initiative involves a contractor to write the first draft of the guidelines, for these guidelines to be focus-tested by Aboriginal stakeholder, revisions to be made and then for these guidelines to receive approval from the National Aboriginal Reference Group on HIV/AIDS (NARGHA) and Health Canada.	Administrative Guidelines for Non-reserve Aboriginal HIV/AIDS funding. Contractor report re focus group.	Clear guidelines based on the recommendations received from Aboriginal Stakeholders during the Roundtable process.
HIV/AIDS Initiative: Canadian Association of Nurses in AIDS Care, Phase II	Continuation of the mentorship project for nurses in AIDS care in collaboration with four nursing organizations. Reach: Canadian Aboriginal Nurses Association.	Development of a mentorship framework/curriculum for HIV/AIDS nurses; final report.	Better trained nurses in AIDS care; Increased nursing resources. Better care to persons living with HIV/AIDS receiving nursing care.
Special Edition: Native Social Work Journal Laurentian University	Continued support for the development and dissemination of a special journal issue on Aboriginal social work and HIV/AIDS. This journal will be geared toward professional knowledge-building and training for social workers in the psycho-social area of the continuum of services from prevention to care, treatment and support.	Social Work Journal - Special Edition.	Increased awareness of HIV/AIDS imp;act for Aboriginal Social Workers. Increased knowledge and capacity to serve for professional social workers.
HIV and Sexual Assault Brochure - Ethnoculture Adaptation (Jointly funded with FNIHB)	The recently developed HIV and sexual assault brochure, which is targeted at women survivors of sexual assault, will be culturally adapted and translated into 4 languages. This cultural adaptation will be targeted at Asian women, Aboriginal women, Inuit women and a forth group which is to be determined. Funds will be provided for focus group testing, cultural adaptation, translation and printing within these four groups.	A HIV and sexual assault brochure targeted at women survivors in four languages.	Awareness of the links between HIV and sexual assault among Aboriginal women, Inuit women and ethnocultural women.

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